INTRODUCTION

The Every Woman's Life program is pleased to release its *2007 Program Manual,* which is effective June 30, 2007. In an effort to continually improve the Program Manual, and ensure an exceptional product is available to our providers and partners, we have taken the opportunity to re-evaluate the format, content and clarity of the original manual, which was released in 2006. As a result, several noteworthy changes have been made to improve and strengthen the overall quality and usability of the manual. These changes include the consolidation of the former *Case Management* and *Services* sections into one section, the addition of polices under the *Quality Assurance/Improvement* section, and the general clarification and enhancement of policies to strengthen program requirements.

Over the past five years, the program has undergone significant changes, and proudly achieved many accomplishments. Some of these achievements include:

- Steadily increasing the number of women the program serves,
- Establishing a comprehensive network of Community Health Workers to bridge the gap between the community and health care,
- Meeting and, in some cases, exceeding nationally recognized standards of quality care and fiscal accountability,
- Simplifying the program's data collection and reporting requirements,
- Securing additional state funding to expand program services to younger women, and
- Initiating a pilot colorectal screening project that is available to EWL enrolled women.

We have also expanded and broadened the mission and philosophy of the program moving it from a breast and cervical cancer screening program to a program that focuses and embraces total women's health. Our program now includes breast and cervical cancer screening as well as positive and preventive health messages to help women achieve optimal health. The messages that focus on good nutrition, healthy weight and increased activity can be found in our *New Day Guide,* and are strategically dispersed throughout this manual.

We are very excited about the prospect of new opportunities and program advancements that will further improve the Every Woman's Life program over the next five years, and look forward to working with our providers and community partners to continue to enhance the quality of life for all Virginia women.

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Data Collection, Reporting & Retention

Take care of yourself, and in turn you take better care of your loved ones; Set a good example for your family, children and friends by making healthy choices. www.win.niddk.nih.gov

Title: Client Data Collection Forms

Program Component: Data Collection, Reporting & Retention

Purpose: To identify the data collection forms that must be accurately completed for each client enrolled into the Every Woman's Life (EWL) program.

Responsible Person(s): Provider Site Coordinator or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2007

Policy:
The EWL client data forms collect critical demographic and clinical information on each client enrolled and served through the program. Data fields listed on the forms are required by CDC for national reporting purposes, and are often referred to as the Minimum Data Elements (MDEs). For a detailed description of each data field, refer to the *Data Information Manual* in **Appendix A**.

The EWL program requires that providers complete and submit three data forms for each client served. The forms include the Eligibility Form, Breast Screening and Diagnostic Form, and the Cervical Screening and Diagnostic Form. The Refused/Lost to Follow-Up Form shall be submitted, when indicated. To view the client data forms, refer to the *Data Information Manual* in **Appendix A**.

Providers shall document tumor size and stage following the detection of an invasive cancer on the Breast Screening and Diagnostic Form and the Cervical Screening and Diagnostic Form. Refer to **Appendix B** for breast cancer tumor staging and **Appendix C** for cervical cancer tumor staging.

Providers shall ensure the accuracy and completeness of all client data submitted. For information on how to submit the client data forms and receive payment for services provided, refer to the section - *Reimbursement.*

Title: Technical Reporting Requirements

Program Component: Data Collection, Reporting & Retention

Purpose: To define the reporting requirements for the Every Woman's Life (EWL) program with which provider sites must comply.

Responsible Person(s): Provider Site Coordinator or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2007

Policy:
All of the following reporting requirements must be submitted to the state EWL program by the specified deadline date:

1. Monthly Screening Log – This report captures the EWL providers' self reported new and re-screens each month during the grant period. Provider sites must complete and fax or email the monthly screening log, which captures the number of screens and re-screens for the previous month, by the 5th day of each month to the state EWL program. Refer to **Appendix D** for the Monthly Screening Log form.
2. Community Health Worker Monthly Activity Report – Community Health Worker (CHW) reports are an important indication of the outreach/inreach efforts at a participating provider site. Reports for the preceding month should be filled out by the CHW and faxed to the state office by the 5th day of the following month. Refer to **Appendix E** for the CHW Monthly Activity Report.
3. Mid-Year Progress Report – The Mid-Year Progress Report documents a provider site's progress on their corrective action plan, which is submitted with their annual renewal application. The reporting period covers June 30th through December 31st. Providers must submit their Mid-Year Progress Report electronically to the state EWL program by the deadline date.
4. Annual Renewal Application – Provider sites are required to submit a renewal application annually, which includes contact information, planned outreach activities and corrective action plans for any deficiencies identified. Provider sites must submit the renewal application electronically to the state EWL program by the deadline date.
5. Match Report – Provider sites are required to match $1 of nonfederal resources for each $3 of federal funds they receive. The match report documents the provider's cash and in-kind donations and must be completed and submitted by Fax or electronically by July 31st. Refer to **Appendix F** for the Matching Funds Form.

Title: Retention and Disposition of EWL Program Records

Program Component: Data Collection, Reporting & Retention

Purpose: To delineate the retention and disposition schedule of EWL program records.

Responsible Person(s): Provider Site Coordinator/Case Manager

Effective Date: June 30, 2006
Revised Date: June 30, 2007

Policy:
The Centers for Disease Control and Prevention (CDC) considers data collected as part of the National Breast and Cervical Cancer Early Detection Program a part of the patient medical record, and therefore, subject to state laws related to retention and disposition. EWL program records include forms used to collect demographic and clinical information on women enrolled and served through the EWL program, such as the Eligibility Form, Breast Screening and Diagnostic Form, Cervical Screening and Diagnostic Form and Refused/Lost to Follow-up Form.

Providers must follow the conditions for records retention and disposition for patient medical records outlined under the provisions of the *Virginia Public Records Act, Sections 42.1-76, et. Seq. of the Code of Virginia*. Adult patient medical records shall be retained for 10 years after last treatment then destroyed by shredding or pulping. Patient medical records for the deceased shall be retained 5 years after death or 10 years after the last treatment, whichever is greater then destroyed by shredding or pulping. Prior to the destruction of patient medical records, providers must make an effort to notify patients through a published notice or correspondence.

Enrollment

Did you know that eating 5 or more servings of fruits and vegetables every day might help reduce the risk of cancer?
www.fruitsandveggiesmatter.gov

Title: Eligibility

Program Component: Enrollment

Purpose: To define eligibility criteria for the Every Woman's Life (EWL) Program

Responsible Person(s): Provider Site Coordinator or Designee

Effective Date: June 30, 2006

Policy:
To enroll a woman as a participant in the Virginia EWL program, the woman must be between 18-64 years of age, claim her primary residence in Virginia, have a household income that is 200% of the Federal Poverty Level or less, and have no health insurance or limited health insurance.

All women will be screened for eligibility prior to enrollment in the EWL program. Eligibility will be determined annually. The following are the requirements for eligibility to receive EWL funded services:

a. Female gender (self-declared)
b. Age – must be age 18-64 (self-declared)
c. Income must be 200% of the Federal Poverty Level or less (self-declared).
d. Primary residence in Virginia (self-declared)
e. Uninsured or underinsured (self-declared) - Underinsured is defined as having:
    - Health insurance that does not reimburse for EWL allowable procedures (e.g., mammogram, Pap test)
    - Health insurance that requires a deductible that cannot be met
    - Health insurance that requires out of pocket expenditures, which may prohibit the woman from obtaining health care (e.g., cannot afford co-pay or insurance only pays 20% of the procedure)

Women aged 50 years or older who are not eligible to receive Medicare Part A and B are eligible for enrollment.

Low-income women (200% of poverty or less) who receive Medicare Part A but cannot pay the premium to enroll in Medicare Part B <u>are eligible</u> for program services.

The following women <u>are not</u> eligible for EWL program services:
- Women enrolled in Medicare Part B
- Women enrolled in Medicare with Medicaid as a supplement
- Women who have Medicaid as primary health coverage
- Women who have health insurance (see exceptions listed under e).

If a woman is eligible to receive Medicare benefits, but is not enrolled, she shall be encouraged to enroll.

Men are not eligible to receive EWL screening and/or diagnostic services.

Title: Federal Poverty Guidelines

Program Component: Enrollment

Purpose: To ensure use of current Federal Poverty Guidelines for the purpose of enrolling financially eligible women.

Responsible Person(s): Provider Site Coordinator or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2007

Policy:
As required by law, an annual update to the Federal Poverty Guideline (FPG) is accomplished by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the *Consumer Price Index for All Urban Consumers.*

Each January, the updates to the FPG are published in the *Federal Register* by the Department of Health and Human Services. The Virginia Every Woman's Life program officially adopts the annual updates on the first day of the new fiscal year, which is June 30th.

Title: Mammograms for Women Age 50+

Program Component: Enrollment

Purpose: To ensure 80% of women 45-64 years of age screened through the Every Woman's Life (EWL) program are age 50 and older.

Responsible Person(s): Provider Site Coordinator or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2007

Policy:
The EWL program has a defined priority population, which includes women over the age of 50. Women over 50 are targeted for mammography services since data indicate that the breast cancer incidence rate steadily increases with age, especially after age 50. For this reason, the program requires that for women 45 to 64 years of age, a minimum of **80%** of all reimbursed mammograms should be provided to women **50** years of age and older.

Title: Never/Rarely Screened

Program Component: Enrollment

Purpose: To concentrate outreach, recruitment and enrollment efforts on women never or rarely screened for cervical cancer.

Responsible Person(s): Provider Site Coordinator or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2007

Policy:
The EWL program defines a priority population, which includes women who have never been screened or have not been screened in the past five years for cervical cancer. Research indicates that women who have not had a Pap test in five or more years are most likely to be in the greatest need of medical care. For this reason, at least **20%** of all 45-64 year old women ***newly*** enrolled for cervical cancer screening should be women who have never had a Pap test or have not had a Pap test in the last 5 years.

Quality Assurance and Improvement

Did you know? People who eat a healthy breakfast are more likely to control their weight and have lower cholesterol.
www.mayoclinic.com

Title: Core Performance Indicators

Program Component: Quality Assurance and Improvement

Purpose: To define the core performance indicators, which are used to measure a provider's performance overtime.

Responsible Person(s): Provider Site Coordinator or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2007

Policy:
There are seven core performance indicators that are used to monitor a provider's performance to ensure quality services are delivered in a timely and efficient manner. The indicators focus on client recruitment, completeness of work-up, timeliness of diagnosis, and timeliness of treatment. Providers must meet the seven core performance indicators. Two of the core indicators (i.e., mammograms over 50 and never/rarely screened for cervical cancer) do not pertain to women 18-44 served with state funds. The seven indicators are tracked and reported quarterly using the *Quarterly Performance Indicator Report,* and released to EWL providers for information and educational purposes.

The seven core performance indicators are listed below:

1. Work-Up Completed

Performance Indicator	Minimum Standard
▪ If there is an abnormal breast cancer screening result or a diagnostic workup is planned, a final diagnosis will be recorded.	▪ 90% of records will be complete.
▪ If there is an abnormal cervical cancer screening result or a diagnostic workup is planned, a final diagnosis will be recorded.	▪ 90% of records will be complete.

2. Screening to Diagnosis

Performance Indicator	Minimum Standard
▪ If there is an abnormal breast cancer screening result, the time between the abnormal screening test result and final diagnosis will be no longer than 60 days.	▪ No more than 25% of records will indicate a timeframe of greater than 60 days between an abnormal breast cancer screening test result and the final diagnosis.
▪ If there is an abnormal cervical cancer screening result*, the time between the abnormal screening test result and final diagnosis will be no longer than 60 days. *Defined as ASC-H, high grade SIL, squamous cell cancer, result unknown and presumed abnormal, Pap test from a non-program funded source, abnormal glandular cells, and any pap result [ASCUS, LSIL], which is marked as needing diagnostics.	▪ No more than 25% of records will indicate a timeframe of greater than 60 days between an abnormal cervical cancer screening test result and the final diagnosis.

3. Treatment Started

Performance Indicator	Minimum Standard
▪ If there is a final diagnosis of breast cancer, appropriate treatment will be initiated.	▪ 90% of records will indicate treatment was initiated.
▪ If there is a final diagnosis of CIN II+, appropriate treatment will be initiated.	▪ 90% of records will indicate treatment was initiated.

4. Diagnosis to Treatment

Performance Indicator	Minimum Standard
▪ If there is a final diagnosis of breast cancer or a pre-cancerous condition, the time between cancer diagnosis and initiation of treatment will be no longer than 60 days.	▪ No more than 20% of records will indicate a timeframe of greater than 60 days between a final diagnosis and the initiation of treatment.
▪ If there is a final diagnosis of cervical dysplasia or pre-cancer (i.e. CIN II, CIN III/CIS), the time between diagnosis and the initiation of treatment will be no longer than 90 days.	▪ No more than 20% of records will indicate a timeframe of greater than 90 days between a final diagnosis of cervical dysplasia or pre-cancer (i.e. CIN II, CIN III/CIS) and initiation of treatment.
▪ If there is a final diagnosis of invasive cervical cancer, the time between diagnosis and initiation of treatment will be no longer than 60 days.	▪ No more than 20% of records will indicate a timeframe of greater than 60 days between final diagnosis of invasive cervical cancer and the initiation of treatment.

5. Missing or Unknown Stage

Performance Indicator	Minimum Standard
▪ The stage at diagnosis will be recorded for women diagnosed with invasive cervical cancer or breast cancer.	▪ Percent of women with missing stage at diagnosis will be less than 1%. ▪ Percent of women with unknown stage at diagnosis will be less than 10%.

6. Mammograms Over 50

Performance Indicator	Minimum Standard
▪ The majority of mammograms provided should be to women between 50 and 64 years of age.	▪ A minimum of 80% of mammograms provided to program eligible women who are 45 to 64 years of age must be provided to women over age 50.

7. Never/Rarely Screened

Performance Indicator	Minimum Standard
▪ The provider will target for enrollment never or rarely screened women, defined as women who have never had a Pap test, or who have not had a Pap test within 5 years. *Does not apply to 18-44 year old women served using state funds.*	▪ A minimum of 20% of newly enrolled women who receive a Pap test will meet the criteria for having been never or rarely screened.

Title: Planned Interventions to Enhance Provider Site Performance

Program Component: Quality Assurance and Improvement

Purpose: To ensure quality services are delivered through the Every Woman's Life program.

Responsible Person(s): State EWL Quality Assurance/Improvement Nurse and Provider Site Coordinator or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2007

Policy: Quality assurance and improvement entails the use of established standards, systems, policies and procedures to monitor, assess and identify practical methods for improvement. To ensure quality services are provided, provider site visits or conference calls will be scheduled periodically to identify areas of improvement and to collaboratively develop action steps to improve provider performance. Site visits/calls will primarily be initiated when problems are identified through the *Quarterly Performance Indicator Report (QPIR).* Providers failing to meet the same performance indicator for two consecutive quarters will be scheduled a site visit/call within 60 calendar days after the release of the *QPIR* report. Other data tracking reports may also generate a provider site visit/call. Additionally, site visits/calls may be initiated by the provider site or initiated to identify and discuss best practices.

In advance, the state EWL program will coordinate the date, time and place of the site visit/call through the provider site coordinator or designee. At least 10 calendar days prior to the visit/call, an agenda will be electronically sent to the provider with a list of discussion topics. The purpose of the site visit/call is to allow state and provider site staff an opportunity to identify and discuss the issues surrounding the problem(s), and to brainstorm and formulate realistic action steps to improve the provider's performance, and ensure compliance with all program standards. Participants will include the state EWL team and provider site staff, including the medical director (or designee), nurse manager, coordinator/case manager, community health worker (if there is one) and fiscal administrator. For site visits, the state EWL team reserves the right to conduct a record review during the visit, if deemed necessary (*see Problem-Focused Medical Record Review Policy).*

The state EWL Quality Assurance & Improvement Nurse will summarize the provider's strengths and identify opportunities for improvement within 30-days of the site visit/call. A standardized template to assist with the development of an improvement plan will accompany the summary. The provider will respond to the issues identified in the site visit/call summary with an improvement plan within 30

days of receiving the summary. To complete the improvement plan, providers shall list specific objectives and activities to improve performance, designate all staff responsible for implementing the activities, and a realistic timeline for completion. The improvement plan will be reviewed, modified, if necessary, and approved by the state EWL Quality Assurance/Improvement Nurse upon receipt, and will remain in effect until the provider meets the performance indicator(s) for two consecutive quarters or the issues are resolved.

Title: Problem Focused Medical Record Review

Program Component: Quality Assurance and Improvement

Purpose: To assess compliance with EWL program standards and ensure quality services are delivered through the Every Woman's Life program.

Responsible Person(s): Quality Assurance/Improvement Nurse Manager, Provider Site Clinicians and Case Managers

Effective Date: June 30, 2007

Policy:
The *Problem Focused Medical Record Review* is used to gather information concerning a quality assurance or performance issue that is identified through data reports, such as the *Quarterly Performance Indicator Report* or *CDC Feedback Report.*

To initiate a *Problem Focused Medical Record Review*, the QA/I Nurse Manager will send a description of the issue/problem to the provider, and a list of the medical records to be reviewed during an on-site visit. In preparation for the visit, the provider site coordinator/case manager shall have the medical records ready for review.

Following the *Problem Focused Medical Record Review*, the QA/I Nurse Manager will release a report within 30 calendar days of the review date. The report will summarize the issue/problem and the results of the review, and provide specific recommendations. The QA/I Nurse manager will follow up 6 months following the release of the report to assess and document the provider's progress.

Title: Medical Record Documentation

Program Component: Quality Assurance and Improvement

Purpose: To ensure all client encounters are documented appropriately and in a timely manner.

Responsible Person(s): Provider Site Clinicians, Case Managers or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2007

Policy:
The medical record serves many purposes but its primary functions are to document and plan client care, and provide a permanent record of information about the services provided. From a risk management standpoint, the medical record serves as a legal document that completely and accurately reflects the care provided to the client. Although healthcare facilities embrace and follow standards for medical record documentation, these standards and procedures may very slightly from one institution to the next.

The EWL program contracts with public (health departments) and private (hospitals, physician offices, etc.) agencies/organizations, to provide breast and cervical cancer screening services. Documentation by Exception[1] is the standard for public health departments and shall be used to document all EWL client encounters. Private EWL providers shall follow the documentation policy endorsed by their individual agency or organization. All EWL providers (public and private) shall follow the medical record documentation policies endorsed by their agency/organization to record client:

- Assessments,
- Interventions,
- Clinical services,
- Referrals,
- Education, and
- Responses.

Providers may use the Client Education Checklist **(Appendix G),** and Client Services Flow Sheet **(Appendix H)** to easily organize and document education to document education and services provided to EWL enrolled women. These forms are ***optional*.**

[1] Documentation by Exception is a system of documenting exceptions to expected findings or disease progression. DBE is based on the premise that a client has manifested a normal response to all interventions unless an abnormal response is charted. Murphy, Ellen *Charting by Exception. AORN Journal, Nov. 2003*

Reimbursement

Small steps, big rewards: Walk during your lunch hour
www.smallstep.gov

Title: Reimbursement for EWL Program Services

Program Component: Reimbursement

Purpose: To define the payment policy for screening services provided under the auspices of the EWL program.

Responsible Person(s): Provider Site Coordinator or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2007

Policy:
The EWL provider shall receive compensation for breast and cervical cancer screening and related services in the form of a per person capitation rate. The capitation rate is calculated using historical EWL program utilization data, case management fees, and the actual costs for services, which are based on Virginia Medicare reimbursement rates for approved CPT codes covered by the EWL program. The capitation rate for a 12-month contract year and all renewals is $320 per person screened. For counties and cities located in the northern Virginia area[2], the capitation rate is $350 per person screened. The capitation rate includes the cost of providing breast and cervical cancer screening services, including short-term follow-up visits that occur within a 12-month period[3], plus the cost of diagnostic tests for the percentage of women who will need them. The capitation rate also supports case management services for managing women with abnormal breast and/or cervical screening results.

To receive the approved capitation rate, EWL providers shall submit an original invoice plus the three required data forms for each client (e.g., Eligibility Form, Breast Screening & Diagnostic Form, and Cervical Screening & Diagnostic Form). Screening information must be complete and all diagnostic information must be entered, if diagnostic tests were performed. A copy of the Invoice/Client Screening List can be found in **Appendix I**. Refer to the *Data Information Manual* in **Appendix A** for the required client data forms.

Upon receipt of the invoice/client data form packet, the EWL Data Manager will review the data forms for accuracy and completeness and will contact the provider site by fax or telephone to request any missing information. Provider sites shall respond to all requests for missing information in a timely manner. If missing information is not provided, invoices will be adjusted accordingly to reflect clients not approved for payment. For clients approved for payment, 'YES'

[2] Northern Virginia cities and counties include: Cities of Alexandria, Fairfax, Falls Church, Manassas, Manassas Park, and the counties of Arlington, Fairfax, Loudoun, and Prince William.

[3] Follow-up visits involve additional screening and diagnostic procedures that are performed within 11 months of the initial screening exam.

will be entered on the Client Screening List; a 'NO' will be entered for clients not approved for payment. The EWL Program Director shall approve the invoice within 30 calendar days of its receipt, and forward to the agency Business Unit for payment processing. A copy will be faxed to the provider site.

The approved capitation rate will only be paid for clients that have received a clinical breast exam, mammogram, pap test and pelvic exam, unless the procedure is marked – refused, not needed, or done recently. However, in order for payment to occur the client must have at least received a mammogram. For example, a client that receives a Pap test and clinical breast exam but no mammogram will not be reimbursed. Exception: The capitation rate will be approved for clients that received a mammogram elsewhere, and were referred into the EWL program for diagnostic testing to rule out cancer.

Providers will **not** be reimbursed for clients aged 18-39 that receive a clinical breast exam to rule out the need for additional diagnostic testing. Providers will only receive reimbursement for clients aged 18-39 that received diagnostic tests to rule out cervical and/or breast cancer.

Providers that fail to submit an invoice and the required client data forms to the state EWL program within **90 calendar days** of the date of the last screening exam (e.g., CBE, Pap test, mammogram) shall forfeit the right to payment.

Close out procedures issued each year for the month of June will include data form submission and reimbursement instructions that will vary from the standard reimbursement policy and procedure.

Procedure:

1. Complete all information on the required data forms, which include the Eligibility Form, Breast Screening and Diagnostic Form and Cervical Screening and Diagnostic Form.

2. Customize the invoice with your organization's letterhead.

3. Complete an invoice for federal screens, if requesting payment for clients aged 45-64.

4. Complete an invoice for state screens, if requesting payment for clients aged 18-44.

5. Include the following information on the invoice:

- Invoice date
- Federal Tax ID#
- Invoice #
- Contract #

- Amount of funds requested (for client screenings, list the number of clients you are requesting payment for and the requested amount in the appropriate space)
- Organization name and address where payment should be mailed

6. Complete an invoice for <u>one</u> type of expense only. For example, a request for reimbursement of federal screens and a request for community health worker funds should be submitted on two separate invoices. **Health departments do not need to submit an invoice to request funds for the Community Health Worker**.

7. Complete the appropriate Client Screening List. Enter the invoice date and invoice number. List the client name and screening date of service, and number the client list. List clients 45-64 years of age on the **Federal** Client Screening List, clients 18-44 years of age on the **State** Client Screening List.

8. Group all follow-ups by age (e.g., 18-44 or 45-64) and list them on the Follow-Up Client Screening List. Attach this list to the appropriate invoice, depending upon the age group.

9. Attach the Client Screening List and Follow-Up Client Screening List to the appropriate invoice and mail it, with the completed data forms, to:

Virginia Department of Health
Every Woman's Life Program
ATTENTION: DATA MANAGER
109 Governor Street, 8th Floor
Richmond, Virginia 23219

Services

The average adult loses about 10 cups of water daily. To maintain your body's fluid balance, you need to replace it each day.
www.eatright.org

Title: Client Education

Program Component(s): Services

Purpose: To ensure that all clients enrolled in the Every Woman's Life program receive important health information emphasizing the importance and purpose of regular breast and cervical screening exams as well as healthy lifestyle behaviors.

Responsible Person(s): Provider Site Case Managers, Clinicians or Designee

Effective Date: June 30, 2007

Policy:
Client education is an essential and fundamental component of the EWL program. Health information provided assists clients in making positive lifestyle choices and decisions, and provides critical information about the importance of routine cancer screening exams. Case managers, clinicians or their designee shall:

1. Provide information, that is culturally and linguistically appropriate and understandable for visually/hearing impaired women, about the purpose of clinical breast exams, mammograms and/or Pap tests when they enroll in the program. Emphasis should be placed on the message that routine screening lowers mortality from breast cancer and decreases a woman's chances of developing invasive cervical cancer, and

2. Provide information on other age appropriate cancer screenings (e.g., colorectal screening over age 50) to women enrolled in the program.

Case Managers, clinicians or their designee may also provide health information on key topics which encourage a healthy lifestyle (e.g., low fat diet, increased activity) to women enrolled in the program to lower the risk of chronic diseases, such as heart disease, high blood pressure and diabetes. Refer to the *New Day Guide* for ideas on how to incorporate women's health messages into health care.

Title: Cervical Services for Women Age 18–39

Program Component: Services

Purpose: To ensure women under the age of 40 with high-grade cervical abnormalities receive appropriate cervical diagnostic services through the Every Woman's Life program.

Responsible Person(s): Provider Site Clinicians and Case Managers

Effective Date: June 30, 2006
Revised Date: June 30, 2007

Policy:
The EWL program provides cervical diagnostic services (e.g., colposcopy) to eligible women between the ages of 18-39 that are referred to the program as a result of a high-grade cervical abnormality test result. Women within this age range are typically screened and referred to the EWL program through family planning clinics or other health care providers. The EWL program **does not** cover routine cervical screening services, such as a Pap test, for this age group.

Cervical abnormalities that warrant cervical diagnostic and case management services include:

1. Low-Grade Squamous Intraepithelial Lesion (LSIL)
2. High-Grade SIL (HSIL)
3. Atypical Glandular Cells (AGC)
4. Squamous Cell Carcinoma

Depending on funding and the clinical plan of care, two additional cervical abnormalities that *may* warrant cervical diagnostic and case management services, include:

1. Atypical Squamous Cells of Undetermined Significance (ASCUS) with Positive Human Papilloma Virus (HPV)
2. Atypical Squamous Cells - Cannot Exclude High Grade Squamous Intraepithelial Lesion (ASC-H)

Title: Breast Services for Women Under Age 40

Program Component: Services

Purpose: To ensure women with breast symptoms under age 40 receive appropriate diagnostic services through the Every Woman's Life program.

Responsible Person(s): Provider Site Clinicians and Case Managers

Effective Date: June 30, 2006
Revised Date: June 30, 2007

Policy:
The EWL program provides breast diagnostic services (e.g., diagnostic mammogram, ultrasound) to eligible women between the ages of 18-39 that are symptomatic for breast cancer. Symptomatic is defined as the presence of:

- A discrete palpable mass
- Bloody or serous nipple discharge
- Nipple or areolar scaliness
- Skin dimpling, retraction, or inflammation

A clinical breast examination (CBE) must be performed on all symptomatic women to confirm the presence of breast symptoms. An EWL clinician or a non-EWL clinician may perform the CBE. If a non-EWL clinician performs the CBE, the case manager must obtain the results of the exam. Once a CBE confirms the presence of breast symptoms, the client shall be referred for imaging studies as determined by the breast algorithm (**Appendix J**).

Women within this age group that have received a screening mammogram with abnormal results are also eligible to receive breast diagnostic services.

Women within this age range are typically screened and referred to the EWL program through health department clinics or other health care providers.

The EWL program **does not** cover routine breast screening services, such as a screening mammogram, for *Asymptomatic* women within this age group, even if they are considered to be at high risk (e.g., women who have a personal history of breast cancer or first degree relative with pre-menopausal breast cancer).

Title: Cervical Cancer Screening and Pelvic Examinations for Women Age 40 - 64

Program Component: Services

Purpose: To ensure that eligible women are provided cervical cancer screening and clinical pelvic examinations.

Responsible Person(s): Provider Site Clinicians, Coordinators or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2007

Policy:
The EWL program promotes an *annual* gynecological exam, which includes a pelvic exam and Pap test. Although an annual pelvic exam is not considered the screening exam to identify uterine or ovarian cancer, it remains the standard of care, and includes a bimanual exam and vaginal inspection with speculum. The primary purpose of the Pap test is to identify pre-cancerous and cancerous cervical lesions at an early stage. Clinicians shall obtain a Pap test from women who have an intact cervix. The Pap test can be the conventional slide or liquid-based cervical cytology (LBT) method.

<u>Cervical Cancer Screening Intervals – Conventional</u>
The Coordinator or the designee shall ensure Pap tests will be obtained on an annual basis unless the woman has had:

1. Three consecutive normal **conventional** Pap test results documented within a 60-month period. Once this occurs, the screening interval shall then increase to once every three years.

    a. To calculate the time period for the three normal screening tests, the first test date should be considered “month 0,” the second test would occur around month 12-24. The third Pap test would be between 24-36 months or twelve months from the second test.

<u>Cervical Cancer Screening Intervals – Liquid-Based</u>
The screening interval using the liquid-based test is every **two years**. The Coordinator or the designee shall ensure a liquid-based Pap test is obtained on a biannual basis unless the woman has had:

1. Three consecutive normal **liquid-based** test results documented within a 60-month period. The screening interval shall increase to once every three years.

b. The screening interval shall increase to once every three years. To calculate the time period for the three normal screening tests, the first test date should be considered “month 0,” the second test would occur around month 24, and the third around month 48.

Pap Test Reporting

Pap test results must be reported using the Bethesda System 2001. Refer to **Appendix K.**

Abnormal Pap Test Result

An abnormal cervical screening test result requires following policies for follow-up of abnormal cervical cancer screening tests. *Refer to the policy - Managing Women with an Abnormal Cervical Screening Result*.

HPV DNA Testing

HPV DNA testing is an allowable procedure if used in follow-up of an ASC-US result from the screening exam, or for surveillance at one year following an LSIL Pap test without evidence of CIN on colposcopy-directed biopsy. **It is not reimbursable as a screening test.** Providers should specify the high-risk HPV DNA panel since screening for low-risk genotypes of HPV is not permitted.

Pap Test Following a Hysterectomy

EWL program funds **cannot** be used to pay for cervical cancer screening in women with complete hysterectomies (i.e., those without a cervix), unless the hysterectomy was performed due to cervical neoplasia (precursors to cervical cancer) or invasive cervical cancer. The presence of a cervix can be determined on physical exam. EWL program funds **can** be used to pay for an initial examination (i.e., pelvic exam) to determine if a woman has a cervix.

Title: Breast Cancer Screening for Women Age 40 - 64

Program Component: Services

Purpose: To ensure women between the ages of 40-64 are provided clinical breast exams and screening mammograms.

Responsible Person(s): Provider Site Clinicians, Coordinators or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2007

Policy:
The primary purpose of regular breast cancer screening is to detect pre-cancerous or cancerous lesions at the earliest stage, and refer promptly for treatment. The clinical breast examination and mammogram are two important tests used in breast cancer screening.

Clinical Breast Examination
The clinical breast examination (CBE) is an important contribution to breast cancer screening. The CBE can detect some cancers not found by mammography, though this happens infrequently. The more important contribution of the CBE is the opportunity for education about normal breast composition, self-breast examination (SBE), and breast cancer.

Clinicians shall perform at least one CBE annually on all clients enrolled in the Every Woman's Life program. The CBE shall consist of a review of the clinical history, visual inspection and palpation, and patient education concerning SBE. Refer to **Appendix L** for Clinical Categories for a CBE.

Screening Mammogram
Enrolled women shall receive an annual screening mammogram performed by a Radiological Technologist certified in mammography and read by a qualified Radiologist. The interval between screening mammograms shall not be less than 12 months. Mammogram results must be reported using the American College of Radiology Breast Imaging Reporting and Database System (BI-RADS). Refer to **Appendix M** for BI-RADS categories. If a woman receives an abnormal screening test result policies for follow-up of abnormal breast cancer screening results must be followed. *Refer to the policy - Managing Women with an Abnormal Breast Screening Result.*

Digital Mammography and Computer-Aided Detection (CAD)
Digital mammography is an allowed procedure. EWL authorized providers must reimburse for this procedure at the conventional film mammography Medicare reimbursement rate. CAD is not an allowable procedure under the EWL program.

Title: Managing Women With An Abnormal Cervical Screening Result

Program Component: Services

Purpose: To ensure women receive appropriate diagnostic and follow-up services through the Every Woman's Life program.

Responsible Person(s): Provider Site Clinicians and Case Managers

Effective Date: June 30, 2006
Revised Date: June 30, 2007

Policy:
The management of women whose cervical cancer screening tests yield abnormal results relies on a body of scientific literature that is constantly growing and changing. The Every Woman's Life establishes clinical policies and protocols in close consultation with the Medical Advisory Committee, and in consideration of standards established by organizations such as the American Society of Colposcopy and Cervical Pathology (http://www.asccp.org), and the American College of Obstetrics and Gynecology (http://www.acog.org/).

Algorithms for the management of abnormal cervical screening results are found in **Appendix N.**

Case management services are required for the following abnormal cervical screening results:

1) Low grade squamous intraepithelial (LSIL)
2) High grade squamous intraepithelial lesion (HGSIL)
3) Atypical glandular cells (AGC)
4) Squamous cell carcinoma

Title: Managing Women With An Abnormal Breast Screening Result

Program Component: Services

Purpose: To ensure women receive appropriate diagnostic and follow-up services through the Every Woman's Life program.

Responsible Person(s): Provider Site Clinicians and Case Managers

Effective Date: June 30, 2006
Revised Date: June 30, 2007

Policy:
The management of women whose mammogram and/or clinical breast exam yield abnormal results relies on a body of scientific literature that is constantly growing and changing. The Every Woman's Life establishes clinical policies and protocols in close consultation with the Medical Advisory Committee, and in consideration of standards established by organizations such as the National Comprehensive Cancer Network (http://www.nccn.org/) and the American College of Radiology (http://www.acr.org/).

Guidelines for the management of abnormal breast screening results are found in **Appendix J.**

Case management services are required for the following abnormal breast screening results:

5) Clinical Breast Exam that is abnormal or suspicious for cancer. This includes the clinical categories of:
    a. Discrete palpable mass,
    b. Bloody or serous nipple discharge,
    c. Nipple or areolar scaliness, and
    d. Skin dimpling, retraction or inflammation.

6) Abnormal mammography results, including the following American College of Radiology categories (for more detailed description, see **Appendix M**):
    a. BIRADS – 3: Probably benign finding
    b. BIRADS – 4: Suspicious abnormality
    c. BIRADS – 5: Highly suggestive of malignancy

Title: Services for Women Over 64 Years of Age

Program Component: Services

Purpose: To ensure that eligible women over the age of 64 receive services if eligible.

Responsible Person(s): Provider Site Case Manager or Designee

Effective Date: June 30, 2006

Policy:
If a woman is eligible to receive Medicare benefits, but is not enrolled, she should be encouraged to enroll. Women over 64 years of age that do not qualify for Medicare may be eligible to receive EWL program services provided they meet the program's eligibility criteria.

Title: Routine Screening Services

Program Component: Services

Purpose: To ensure that women are provided mammograms and Pap tests at regular intervals following their initial screening examinations.

Responsible Person(s): Provider Site Case Manager or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2007

Policy:
Rescreening is the process of returning for a screening test within a predetermined interval level. The state goal is to achieve a rescreen rate of 75%, that is, 75% of the women screened in any given year should return within 12 to 18 months after their last screening. There must be at least 12 months between screening tests for the screening to be considered a rescreen.

Priority for mammograms and Pap tests should be given to eligible women previously screened through the Every Woman's Life program. Providers shall also ensure that women finishing treatment under the Breast and Cervical Cancer Prevention Treatment Act (BCCPTA) be contacted and re-enrolled, if eligible, into the EWL program once their cancer treatment is completed.

Providers shall develop and implement a reminder system to facilitate the tracking of women previously screened. The reminder system should be systematic and comprehensive (capturing mammography and Pap test screening examinations), and applied consistently following the state's defined re-screening intervals.

Treatment

Need a reason to kick the smoking habit? In just 20 minutes after quitting, blood pressure drops and the temperature of your hands and feet increases to normal.
www.cancer.org

Title: Medicaid Treatment Act

Program Component(s): Treatment

Purpose: To define the criteria and procedure for enrollment into the Medicaid Treatment Act.

Responsible Person(s): Provider Site Coordinator or Case Manager

Effective Date: June 30, 2006
Revised Date: June 30, 2007

Policy:
Who is Eligible?
Women who are screened through the Every Woman's Life (EWL) program, diagnosed with cancer or a pre-cancerous condition, and certified as needing treatment by an EWL provider, may be eligible for treatment by Medicaid under the **Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA).** Pre-cancerous conditions of the breast and/or cervix are those that are defined by a health care professional as needing treatment. Treatment is defined as all forms of treatment prescribed by a health care professional, including palliative care.

The Deficit Reduction Act of 2005, effective February 8, 2006, requires all applicants and recipients of Medicaid that claim to be US Citizens provide proof of identity and citizenship. The provision requires applicants to provide proof of citizenship and identity when applying for Medicaid on or after 7/1/06, and for all recipients of Medicaid at the time of their first re-determination of eligibility on or after 7/1/06. Provision of these documents is a one-time activity, and once provided, will not be required again.

A birth certificate can be used to document citizenship. If the applicant does not have a birth certificate and needs assistance in obtaining one, the applicant can request assistance from the Department of Social Services (DSS) office. A driver's license can be used to document identity. A passport or naturalization certificate can be used to document both citizenship and identity. Original documents must be provided to the DSS. For a complete list of acceptable documents to document citizenship and identify, contact the local DSS office.

If an eligible woman is seen by a health care professional at any non-EWL health care provider site because of a symptom that is suspicious for cancer, she is eligible to be referred to an EWL provider to be screened and/or diagnosed for breast and/or cervical cancer. If the woman is then diagnosed with breast or cervical cancer (or a pre-cancerous condition), she may be eligible for Medicaid treatment services under the BCCPTA.

If a woman is screened by an EWL provider who detects an abnormality, but chooses to be evaluated by a non-EWL provider who eventually detects and diagnoses cancer, she may be eligible for Medicaid treatment services under the BCCPTA.

The health care professional shall determine when the course of treatment is completed. Some clients will have a very short course of treatment while others may have a prolonged course of treatment. If a woman's Medicaid eligibility is terminated because she no longer requires treatment, she is eligible for re-enrollment in the EWL program for breast and cervical cancer screening services as long as she meets the program's eligibility requirements. If she is subsequently diagnosed with breast or cervical cancer (or a pre-cancerous condition), she may be eligible for re-enrollment in Medicaid for the new cancer treatment, even if it is a recurrence of the previous cancer.

Who is Not Eligible?

Women that have already received a cancer diagnosis for breast and/or cervical cancer but were not screened or diagnosed by an EWL provider for that condition are not eligible for Medicaid payment for treatment of that cancer under the BCCPTA.

If a woman indicates that she is not a US citizen, receives SSI, is pregnant, or has a child under the age of 19 living with her, her application will require further evaluation by the Department of Social Services. She may not be eligible for treatment under the BCCPTA. Many qualified aliens who arrived in the U.S. after August 21, 1996 are banned from receiving Medicaid for 5 years beginning with their date of entry with a qualified alien status. The five-year ban does not apply to certain refugees, asylees, and certain other groups. The determination of her eligibility for Medicaid will lie with the DSS.

Women that have creditable health insurance coverage are not eligible for treatment under the Medicaid Treatment Act. Creditable health insurance includes:

- A group health plan;
- Health insurance coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;
- Medicare;
- Medicaid;
- Armed forces insurance;
- A medical care program of the Indian Health Service or tribal organization;
- A state health risk pool.

If a woman has health insurance coverage that does not include treatment of breast or cervical cancer due to a period of exclusion or exhaustion of lifetime benefits, her coverage is still considered to be creditable and she is not eligible for treatment under the BCCPTA. Similarly, if a woman has creditable health insurance, but a high deductible, she is not eligible for enrollment under the BCCPTA covered group.

Examples of non-creditable health insurance include, a disease specific policy (e.g., cancer policy), and dental, vision, or prescription only policies with no other coverage. In these instances, the woman could be eligible for treatment under the BCCPTA.

The EWL provider shall assure that women who are not eligible for Medicaid benefits under the Medicaid Treatment Act receive appropriate treatment services. The provider shall explore community resources, such as charity care, faith-based organizations, and health institutions that serve indigent populations to ensure treatment services are provided.

Other Information Related to the BCCPTA

The DSS will re-determine Medicaid eligibility on an annual basis. At the time of the annual re-determination, the woman must provide a statement from her health care professional verifying continued treatment for breast and/or cervical cancer.

The client shall receive full Medicaid coverage for as long as she is in cancer treatment. There is a co-pay associated with Medicaid services and clients are responsible for paying the co-pay, which is dependent upon the type of service they receive. For example, for an inpatient hospital stay the co-pay is $100.00 per admission and $1.00 per clinic visit.

Procedure:

Once a client is diagnosed with breast or cervical cancer or a pre-cancerous condition and deemed in need of treatment by a health care professional, the following procedures must take place:

1. The coordinator/case manager will instruct the client to gather the appropriate verification to document citizenship and identity, if they claim U.S. citizenship.

2. The client will complete and sign a BCCPTA Medicaid Application Form in **Appendix O.** The coordinator/case manager must sign this form.

3. The coordinator/case manager will immediately forward the completed copy of the BCCPTA Medicaid Application Form to the county or city DSS office where the client resides.

4. The coordinator/case manager will maintain contact with the client to ensure that treatment has begun and that any barriers to receiving treatment are addressed.

5. The coordinator/case manager will send a written letter to the client, and a copy to the treating health care professional, with the following information:
    a. The client must complete the Medicaid Re-Determination Form annually. They can either have their health care professional complete the certification section of the form or have the health care professional verify in writing that further treatment is needed. The Medicaid Re-Determination Form is available through the local DSS office.
    b. The client must notify their local DSS office when their treatment course is completed or if there is a change in Medicaid eligibility status (e.g. obtain private insurance). Eligibility for Medicaid through the BCCPTA ends when treatment has ended.

6. The coordinator/case manager shall re-assess the client's eligibility for re-enrollment into the EWL program when cancer treatment is completed.

For more detailed information on the Medicaid BCCPTA Policy, refer to **Appendix P.** For Frequently Ask Questions related to the BCCPTA, refer to **Appendix Q.** For consultation on specific cases, contact the state EWL office.

Appendix

Portion Distortion! Twenty years ago, a typical restaurant portion of spaghetti and meatballs was about 500 calories. Today, a serving is over 1,000 calories! Split your meal with a friend, or wrap up half and save for dinner tomorrow.
http://hp2010.nhlbihin.net/portion

Appendix A

Table of Contents

Data Management

Data compiled from the EWL screening forms are used to track the Program's performance and compliance with EWL standards, including:

- The patient's eligibility for EWL services.
- Screening and re-screening of program-eligible clients.
- Assuring that the clinical breast examination, the screening mammogram, the screening Pap test and other tests follow EWL medical guidelines and protocols.
- Documenting the timeliness of a client's completion of diagnostic work-up (or the client's refusal of workup or being lost-to-follow-up).
- Documenting the timeliness of a client's initiation of treatment (or refusal of treatment or being lost-to-follow-up), in the event that she is diagnosed with breast or cervical cancer.
- Assuring that the client is referred to Medicaid in the event that she is diagnosed with breast or cervical cancer and is eligible for Medicaid services under the BCCPTA.
- Assuring that all client documentation (i.e., MDE data forms) is routed in a timely fashion to the State office as required.

MDE Data Reporting

The Centers for Disease Control and Prevention requires that each state program, including the Virginia EWL, collect and report the minimum data elements (MDEs). These are required data fields that are relevant to client eligibility, quality assurance, and surveillance. The Provider Sites agrees to collect and report to the Program all client data including:

- patient demographics
- patient contact information
- eligibility information
- date and results of breast and/or cervical screening visits
- referral for diagnostic workup
- date and results of diagnostic tests
- diagnosis (incl. staging, tumor size)
- cancer treatment information
- Medicaid enrollment (for cancer treatment)
- CPT codes for screening and diagnostic tests

State EWL programs are allowed to collect additional data for administrative or research purposes.

EWL Data Forms

Below is a brief description of the data forms that are used by the EWL Program:

The *Eligibility Form*, which is the first form to be completed on a potential EWL client, documents that the client meets the Program requirements (e.g., age, residence and income/insurance status) for being eligible to obtain screening services. The Eligibility Form also contains information on how to contact the client (e.g., address, telephone number).

The *Breast Screening and Diagnostic Form* allows clinicians to document the dates and results of the clinical breast exam, screening mammogram, or list the reason for the procedures not being performed. The clinician also documents if diagnostic workup is planned. These forms are also used for documenting diagnostic test dates of services and results that lead up to a final diagnosis. In addition, in cases of diagnosed cancer, the clinician must document cancer staging, tumor size and treatment start date. If the client declines diagnostic workup and/or treatment, it is reported on the Diagnostic Encounter Form under Workup Status or Treatment Status. Also, document if the patient is enrolled in Medicaid for payment of treatment services.

The *Cervical Screening and Diagnostic Form* allows clinicians to document the dates and results of the Pap test or list the reason for the procedure not being performed. The clinician also documents if diagnostic workup, including HPV testing, is planned. These forms are also used for documenting diagnostic test dates of services and results that lead up to a final diagnosis. In addition, in cases of diagnosed cancer, the clinician must document cancer staging, tumor size and treatment start date. If the client declines diagnostic workup and/or treatment, it is reported on the Diagnostic Encounter Form under Workup Status or Treatment Status. Also, document if the patient is enrolled in Medicaid for payment of treatment services.

The *Refused/Lost to Follow Up Form* is completed whenever a client refuses diagnostic tests or treatment or is lost to follow up. Any comments related to the refusal or lost to follow up can be documented on this form.

Client Eligibility Form

*For every woman enrolled in the EWL, there must be an **Eligibility Form** completed. You may either:*

- *obtain the information over the phone or in a face-to-face interview as you screen her for eligibility and enroll her in the program, or*
- *have the client complete the form herself -- the form has been simplified for a low reading level.*

It is strongly recommended that the Case Manager assist the client in completing the Eligibility Form. **The Eligibility Form must be completed prior to the client's first screening service. Otherwise, she is not considered enrolled in the EWL.**

Personal Information

Patient Demographic Information

Provide the client's full name, including middle initial and maiden if applicable, date of birth, and social security number or alien identification number, if available. This aids our search for the client in the state database. Ensure that the information, especially birth date and social security number, is accurate. We request patient name and SSN on each of the forms in order to trace any form back to the client in case forms becomes separated.

If SSN or Alien ID is not available, we recommend that you leave this field blank. However, most legal residents will have either a SSN or Alien ID. A client is not required to provide her SSN or alien ID; however, we strongly encourage that you ask the client to provide it. *Not providing a valid ID may impede her ability to enroll in Medicaid should she be diagnosed with cancer and require treatment.* Please encourage all clients to provide their SSN and relay to them that this information will be kept confidential.

Annual Income

Report the annual household income as the total combined income of all persons, including the client, living in the same household, regardless of whether or not the client is a dependent. If the client is unemployed and has no income, indicate "0". Refer to the current Federal Poverty Guidelines for income thresholds.

Insurance Status

Report whether or not the patient has medical coverage through a private insurer, Medicaid, or Medicare. A woman may be eligible if she has private insurance but has already met her deductible or the insurance does not cover screening services.

Questions for New Clients Only

Referral Source

In order to better target our outreach, we rely on the completion of this section. Please report how the client heard about EWL. For those Sites that are conducting outreach via Community Health Workers, the Sisters Network (applies to certain geographic areas), or other organizations, please write this in next to "Other".

Race and Hispanic Ethnicity

Race and ethnicity are required data fields. Ethnic identification refers to whether or not the client is of Spanish, Hispanic, or Latina origin. Both are mutually exclusive questions: for instance, a client who reports being Hispanic or Latina can also be White or Black. Please encourage your clients to report on both race and ethnic origin. The client is permitted to record more than one racial group.

Language Spoken

In order to better target our outreach and provide services, we rely on the completion of this section. Please report what language the clients speaks every day.

Screening History

In order to identify women who are never or rarely screened for breast or cervical cancer, you must ask the client if or when she last had a mammogram or Pap test prior to being enrolled in the program. Ask the client if she can recall the month and year, or just year, of her last Pap or mammogram. If the client cannot recall an approximate date but indicates that it was more than five years ago, check the box "more than 5 years ago". "Don't know" is also an option for clients who don't recall when.

Office Use Only

The questions in the shaded box are for administrative (office) use only, to be completed by the case manager or other designated EWL staff. Please inform your client that she does not complete the items in the shaded box.

Administrative Site

"Administrative Site" refers to the name of the organization that contracts with VDH to administer the program at the local level. This is different from the screening provider site which performs the actual screening tests. There are fewer Administrative Sites than there are screening sites. An Administrative Provider Site never changes name and can add multiple screening sites.

Case Manager

"Case Manager" refers to the person designated as the client's case manager. She or he should be affiliated with the Administrative Provider Site. This person should also take an active part in completing the data forms and ensuring by his or her signature that the information is valid.

Enrollment Site

"Enrollment Site" is the site where you enrolled the client. Typically, it is a clinic, local health department or hospital. Refrain from referring to temporary outreach sites (e.g., church, salon, workplace) and instead refer to the site where the case manager, health educator, or outreach/enrollment coordinator works from permanently.

Enrollment Date

"Enrollment Date" refers to the date when the patient was enrolled as a new client. For clients who are returning as rescreens, indicate the date when her eligibility was re-assessed.

Client Status

Indicate the client's status – active or inactive. If "Active", indicate if the she is a New Patient or a Rescreen patient. If "Active" also provide additional detail and indicate if the client has a previous history of breast cancer (left or right breast) or if the client has had a hysterectomy by using the check boxes provided.

If "Inactive", list the reason why the patient is no longer active (e.g., has insurance, enrolled in Medicare, income too high, lost-to-follow-up) and the effective date when it was determined that she was inactive.

Client ID

Each new client will automatically be assigned a unique five-digit identification number when we enter her information for the first time into the state database. Anytime that a client returns for rescreening, we will search the database for her name and retrieve her unique identifier. You may use "Client ID" for your own benefit. Otherwise, we will fill in the blank with the program's unique identifier as assigned by the database.

Effective Date

If the client has been inactivated, record the date of the status change.

Eligibility Form
Every Woman's Life - Virginia Department of Health

PERSONAL INFORMATION			
Last Name	First Name	MI	Maiden Name
SSN (or alien ID) / /	Birth Date / /	Age	
Address	City	County	
State	Zip	Home Phone ( ) -	
Work Phone ( ) -	Cell Phone ( ) -	Best Time to Call:	

What is your household income before taxes? $ /Year

How many people live on this income? (including yourself)

Do you have Medicaid? ☐ Yes ☐ No Medicare? ☐ Yes ☐ No ➔If YES ☐Part A or ☐Part B

Private insurance? ☐ Yes ☐ No ➔If YES, has deductible been met? ☐ Yes ☐ No

QUESTIONS FOR NEW CLIENTS ONLY

How did you hear about the Every Woman's Life program? ☐ Brochure ☐ Community Health Worker ☐ Family/Friend ☐ Health Fair ☐ Internet/Web ☐Radio/TV/Newspaper ☐ Other

Ethnicity: ☐ Hispanic ☐ Non Hispanic ☐ Unknown

Do you describe yourself as: (check ALL that apply) ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/ Pacific Islander ☐ Unknown

What language do you speak every day?

Have you ever had a pap test? ☐Yes ☐ No
➔If YES, when was your last Pap test? (month/year) / or ☐ More than 5 years ago ☐ Don't know

Have you ever had a mammogram? ☐Yes ☐ No
➔If YES, when was your last mammogram? (month/year) / or ☐ More than 5 years ago ☐ Don't know

OFFICE USE ONLY
Administrative Site: _____ **Case Manager:** _____
Enrollment Site: _____ **Enrollment Date:** ____ / ____ / ____
Client Status: Active – check one: ☐ **New Patient** ☐ **Rescreen Client ID** _____
Detail: Previous Breast Cancer ☐ **L Br** ☐ **R Br** ☐**Hysterectomy for Cervical Cancer** ☐**Hysterectomy Non Cancer**
☐ **Inactive due to: (list reason)** **Effective Date**

Version 07/0

Breast Screening and Diagnostic Form

The *Breast Screening Section* is a record of the screening cycle, which encompasses a clinical breast exam (CBE), breast self-examination (BSE) instruction, a mammogram for each screening cycle. Date of service, type of procedure, results, and screening provider are recorded on this form.

Once again, patient's name, SSN, Administrative Provider Site, and Client ID are repeated at the top of the form to ensure that they match up with other patient forms, if separated. The visit can fall within three categories: New Patient, Follow-up, or Rescreen. This will help us identify which visits qualify for authorized payment (only new screens and rescreens qualify for payment).

Clinical Breast Examination (CBE)

The CBE is part of the breast screening for which clients are eligible. The CBE is performed prior to the mammogram and its results inform the provider as to whether or not to recommend a diagnostic mammogram or other diagnostic work-up. In the absence of any client-reported symptoms, client risk factor history or abnormal (suspicious for cancer) findings on the CBE, a screening mammogram is instead performed.

Breast Symptoms

Indicate if the client reported any symptoms, including lumpiness, bleeding, scaling, discharge, retraction, etc. This is based on the patient's self-report.

CBE Performed and Date

Indicate if the CBE was performed by checking "Yes" or "No" and provide the date when performed.

CBE Results

There are nine categories the CDC proposed for the collection of the CBE data at the clinical level. These categories are:

- ❑ Normal exam
- ❑ Benign finding (includes fibrocystic changes, diffuse lumpiness or nodularity)
- ❑ Discrete palpable mass*
- ❑ Bloody or serious discharge*
- ❑ Nipple or areolar scaliness*
- ❑ Skin dimpling or retraction*
- ❑ Previous normal CBE in the past 12 months-CBE not performed
- ❑ CBE not performed, other or unknown reason
- ❑ CBE refused

*Any of the above findings requires immediate **diagnostic evaluation**. A diagnostic mammogram alone does not constitute an acceptable diagnostic evaluation. The diagnostic mammogram must be followed by a breast ultrasound, biopsy, FNA, or a referral to a surgeon or breast specialist.

"Previous normal CBE in the past 12 months-CBE not performed" refers to a client who does not require a CBE because she had a previous normal CBE within the past 12 months. If the date of her last CBE exceeds more than 12 months, it is strongly recommended that the client have another CBE performed. If a client had a CBE elsewhere that was not normal, it is recommended that a repeat CBE and appropriate diagnostic work-up be done.

In the case where a CBE was recommended by the provider but not performed, you should report **"CBE not performed, other or unknown reason"** or **"Refused"** in the CBE field. This refers to a woman who refuses to have the CBE performed, who does not keep her screening appointment or who could not be scheduled to have a clinical breast exam. Additional attempts should be made to reschedule the client.

CBE Funding Source

Indicate "Yes" to Question 5, if the CBE was fully or partially paid for by EWL funds.

Mammogram

All women, regardless of age, who are enrolled in the EWL Program, are eligible for a mammogram. The CBE and mammogram are used in conjunction for breast cancer screening.

Mammogram Type

Typically, a patient who is asymptomatic and has no breast history will have what is referred to as a screening mammogram. In other cases, when the woman is symptomatic or she has be at risk, according to her health or family history, the initial mammogram ordered is "diagnostic" rather than screening.

Mammogram Results

There are ten categories used for the collection of the mammogram results. These categories are:

- Negative
- Benign finding
- Probably benign
- Suspicious abnormality
- Highly suggestive of malignancy
- Assessment is incomplete
- Unsatisfactory, film cannot be interpreted (Repeat mammogram)

- ❑ Not needed or done previously elsewhere with non EWL funds
- ❑ Needed but not performed (includes refused)
- ❑ Result unknown, presumed abnormal, from non-program funded source

- **Assessment Incomplete:** The radiologist is recommending additional imagery (magnification or additional views) be performed before arriving at a final interpretation. This differs from "incomplete assessment", which has no correspondence to the BI-RADS system. In the latter, the radiologist may want to review older films for comparison in order to better interpret a finding on the current mammogram.
- **Unsatisfactory, film cannot be interpreted**: The mammogram is technically unsatisfactory and cannot be interpreted by the radiologist, in which case, the mammogram should be repeated. Unsatisfactory mammograms should be recorded on the form and submitted as is. The repeated mammogram should be reported and submitted on a new Breast Screening and Diagnostic Form.
- **Result unknown, presumed abnormal, from other funded source**: The client is being referred to the EWL for breast diagnostic workup on the basis of an abnormal mammogram that was performed by a non-EWL provider. The finding is presumed abnormal, and therefore workup is recommended. If the actual result from the outside mammogram is known, it should be fully reported in the Mammogram section (complete the entire section); indicate "No" on Question 9 about the funding source. This result category should be reserved for screening test results that cannot be obtained.
- **Not needed or done previously elsewhere with non EWL funds**: There is no indication that a mammogram is needed because: (1) the client recently—within the last 12 months—received a mammogram from a non-EWL provider; (2) the client recently had a mammogram by the program and is returning for a short-term follow-up not related to breast (e.g., repeat Pap test); (3) the client had a mastectomy and does not require breast cancer screening.
- **Needed but not performed (includes refused):** A mammogram is recommended for this cycle, but was not performed due to the following reasons: (1) the patient refused to have one; (2) the patient is lost-to-follow-up; (3) the patient was unable to obtain a mammogram due to scheduling; (4) the client had another procedure (e.g., ultrasound) done instead of a mammogram. With the latter, indicate that the recommendation was for planned workup.

Mammogram Funding Source

You should report the mammogram as being paid for by the EWL ("Yes") if it was fully or partially funded by EWL funds.

Mammogram Provider

Record the name of the screening site where the mammogram was performed. Refrain from leaving the question blank or using acronyms or abbreviations.

Workup Recommendation

Specify if the radiologist recommended workup based on the mammogram and/or CBE finding. The clinician should be following the guidelines for recommended work-up for abnormal CBE and/or mammogram, as provided by the EWL. If the recommendation is for short-term follow-up—i.e., to repeat the mammogram in six months—indicate "no" on the Workup Plan question.

Breast Diagnostic Procedures

This section is for documenting diagnostic workup, the final diagnosis (if one is reached), and treatment information, if diagnosed with breast cancer. You must complete this section if you have an abnormal CBE and/or mammogram finding, or breast diagnostic workup is recommended.

Diagnostic work-up for abnormal breast findings include the following major diagnostic procedures:

- additional mammographic views (check whether views are unilateral or bilateral)
- ultrasound
- repeat CBE/surgical consult
- fine needle/cyst aspiration
- breast biopsy/lumpectomy

Additional procedures may be performed in conjunction with the breast biopsy or fine needle aspiration. We provided an extensive list of approved procedures. Check (✓) any that apply. If there is a procedure not in the list, write in under "Other" and provide the CPT code.

Indicate which diagnostic test was performed, the procedure date, the procedure site, result, and funding source for the test. If a test was cancelled or not performed because the patient refused or did not show for her appointment, indicate the test as "refused". If the patient refused a diagnostic test, complete the Refused/Lost to Follow up form.

Work-Up Status

Once work-up is completed, indicate the status of workup. Question 17 allows for you to report clients that refuse workup or are lost to follow-up. If the patient refused a diagnostic test, complete the Refused/Lost to Follow up form. In **all** cases of recommended work-up, you should complete Question 17, whether or not you have a final diagnosis.

Final Diagnosis Date

The Date of Final Diagnosis refers to the date of service of the procedure that results in the final diagnosis of cancer (or not cancer). If more than one diagnostic procedure was performed, the date of final diagnosis should be reported as the date of the procedure that provided the definitive diagnosis. For example, if both a diagnostic mammogram and ultrasound were performed and indicate a diagnosis of 'Not cancer', the ultrasound is the procedure that ultimately provides the definitive diagnosis, more so than does the diagnostic mammogram. You should record the date of service of the ultrasound for the Date of Final Diagnosis.

Diagnosis

The diagnosis categories are: breast cancer diagnosed, invasive breast cancer, ductal carcinoma in situ (DCIS), lobular carcinoma in situ (LCIS). "Infiltrating carcinomas" is considered invasive cancer.

Staging and Tumor Size

For cases of invasive cancer, report the tumor stage and tumor size. It is not necessary to report the stage for in situ cancer. The stage and tumor size information can be obtained from your tumor registry or directly from the treating oncologist or surgeon.

For all cases of in situ or invasive cancer, you should complete the Breast Cancer Treatment Status (see below).

Breast Cancer Treatment Status

Treatment Status

For all cases of cancer diagnosed, you should at a minimum complete Question 22 on the status of treatment.

Report the date when treatment was started. **NOTE:** Oftentimes it may be a lumpectomy performed in the course of an excisional biopsy. Report the date of treatment as the date when the biopsy/lumpectomy was performed.

For both Patient Lost to Follow-up and Treatment Refused, report a date when the determination was made—space is provided. If the patient refused treatment, complete the Refused/Lost to Follow up form.

Recommended Treatment

Check (✓) all treatments that are recommended. It is possible that the patient will not start or complete all recommended treatments—just indicate the treatments that are part of the clinician's plan.

Medicaid Enrollment

Indicate if the patient was enrolled in Medicaid under the provisions of the BCCPTA. Please send a copy of the BCCPTA Medicaid Application Form to VDH (and keep a copy for your own records). We will enter the date of enrollment in the state database.

Form Completed by

The Case Manager, or designee, who completed the form must sign and date the Diagnostic Encounter Form. If there are any questions regarding information on the form, the Nurse Consultant will contact that person.

Tips for Completing the Breast Screening and Diagnostic Form

1. If the client is being referred to EWL for diagnostic workup on the basis of an abnormal CBE, which was performed elsewhere, record the date of the CBE, the result of the CBE, and that the CBE was not paid by EWL.
2. If you obtain more than one result, or different results in each breast, record the worse of the two findings.
3. If the client is being seen for a repeat CBE only, indicate on the mammogram result that the mammogram was "not needed…". Do not leave the entire Mammogram section blank.
4. If the mammogram is unsatisfactory, you should submit the Screening Encounter Form with the unsatisfactory finding. The mammogram should be repeated and the information submitted. This will help in tracking the number of unsatisfactory results.
5. If the client is being referred to the EWL for diagnostic evaluation for a breast problem on the basis of an abnormal CBE by an outside provider, obtain and record the results of the mammogram and indicate that the mammogram was paid by EWL.
6. If the first mammogram of a screening cycle is a diagnostic mammogram, it should be documented on the Breast Screening and Diagnostic Form.
7. If the diagnostic mammogram is recommended as *immediate* work-up for an abnormal screening mammogram result, it should be documented.
8. If more than one result is reported—for example, different findings occur within the same breast, or different findings occur in the left and right breasts—report the worse of the two findings. The same applies to the final breast diagnosis.
9. If the result of the final, definitive diagnostic test (e.g., biopsy) is "indeterminate" and you indicate a final diagnosis of either cancer or no cancer, please have a ready explanation for how you reached this diagnosis. An indeterminate result will trigger a call from the Data Manager or Nurse Consultant unless an explanation is provided.
10. Remember: if the client is diagnosed with invasive (infiltrating) cancer, you must report the tumor stage and tumor size using the TNM staging system. Do not submit the pathology report, unless requested, as a substitute for reporting this information on the data form. You are responsible for choosing the correct category on the data form based on information that you obtain. If you have questions about the pathology report, please contact the EWL quality assurance nurse at VDH. If more than one tumor is found, choose the tumor stage/size that is worse.

Breast Screening and Diagnostic Form
Every Woman's Life - Virginia Department of Health

Last Name	First Name	MI	Maiden Name
Admin Site	❑ **New Patient** ❑ **Follow-Up** ❑ **Rescreen**		**SSN (or alien ID)**

CLINICAL BREAST EXAM (CBE)

1. Does the client have breast symptoms? ❑ Yes ❑ No
2. Did the client have a CBE? ❑ Yes ❑ No
3. CBE date: _____ / _____ / _____ (mm/dd/yyyy)
4. What were the CBE results?
   - ❑ Normal exam
   - ❑ Benign finding (includes fibrocystic changes, diffuse lumpiness or (nodularity)
   - ❑ Discrete palpable mass*
   - ❑ Bloody or serous nipple discharge*
   - ❑ Nipple or areolar scaliness*
   - ❑ Skin dimpling or retraction*
   - ❑ Previous normal CBE in the past 12 months – CBE not performed
   - ❑ CBE not performed, other or unknown reason
   - ❑ CBE refused
5. Was the CBE paid by EWL? ❑ Yes ❑ No

***Requires diagnostic mammogram and further diagnostic evaluation.**

MAMMOGRAM

6. Mammogram type: ❑ Screening ❑ Diagnostic
7. Mammogram date: ____ / ____ / ____(mm/dd/yyyy)
8. What were the mammogram results?
   - ❑ Negative
   - ❑ Benign finding
   - ❑ Probably benign
   - ❑ Suspicious abnormality
   - ❑ Highly suggestive of malignancy
   - ❑ Assessment is incomplete
   - ❑ Unsatisfactory, film cannot be interpreted **(Repeat Mammogram)**
   - ❑ Not needed or done previously elsewhere with non EWL funds
   - ❑ Needed but not performed (includes refused)
   - ❑ Result unknown, presumed abnormal, from non-program funded source
9. Was the mammogram paid by EWL? ❑ Yes ❑ No
10. Where was the mammogram performed?_____
11. Was the client referred for **immediate** breast diagnostic workup? ❑Yes ❑ No

DIAGNOSTIC PROCEDURES

12. Additional Mam Views: ❑ Yes ❑ No
❑ Unilateral ❑ Bilateral
Procedure date ___ /____/___(mm/dd/yyyy)
Procedure site:_____
Results:
- ❑ Negative
- ❑ Benign findings
- ❑ Probably benign
- ❑ Suspicious abnormality
- ❑ Highly suggestive of malignancy
- ❑ Assessment incomplete
- ❑ Refused (**Complete Refused/LTFU Form)**

Funding Source: ❑ EWL ❑ Other

13. Ultrasound: ❑ Yes ❑ No
Procedure date _____/_____/____(mm/dd/yyyy)
Procedure site:_____
Results:
- ❑ Normal (WNL)
- ❑ Cystic mass
- ❑ Other benign abnormality
- ❑ Suspicious for malignancy
- ❑ Refused (**Complete Refused/LTFU Form)**

Funding Source: ❑ EWL ❑ Other

14. Repeat CBE/ Surgical Consult: ❑ Yes ❑ No
Procedure date _____/_____/____(mm/dd/yyyy)
Procedure site:_____
Results:
- ❑ Normal (WNL)
- ❑ Benign finding
- ❑ Discrete palpable mass
- ❑ Bloody or serous nipple discharge
- ❑ Nipple or areolar scaliness
- ❑ Skin dimpling or retraction
- ❑ Refused (**Complete Refused/LTFU Form**)

Funding Source: ❑ EWL ❑ Other

15. Fine Needle/ Cyst Aspiration: ❑ Yes ❑ No
Procedure date _____/_____/_____(mm/dd/yyyy)
Procedure site:_____
Results:
- ❑ Not suspicious for cancer
- ❑ Suspicious for cancer
- ❑ No fluid/tissue collected
- ❑ Refused **Complete Refused/LTFU Form**

Funding Source: ❑ EWL ❑ Other

16. Biopsy/ Lumpectomy: ❑ Yes ❑ No
Type of biopsy: ❑ Excisional ❑ Non Excisional
Procedure date _____/_____/____(mm/dd/yyyy)
Procedure site:_____
Results:
- ❑ Normal breast tissue
- ❑ Hyperplasia
- ❑ Other benign changes
- ❑ Refused (**Complete Refused/LTFU Form**)
- ❑ DCIS
- ❑ LCIS
- ❑ Invasive cancer

Funding Source: ❑ EWL ❑ Other

WORK-UP STATUS

17. What is the status of the final diagnosis?
- ❑ Work-up complete
- ❑ Client lost to follow-up (**Complete Refused/LTFU Form**)
- ❑ Workup refused (**Complete Refused/LTFU Form)**

18. Date of final diagnosis: / / (mm/dd/yyyy)

19. Final Diagnosis:
- ❑ Breast cancer not diagnosed
- ❑ Invasive breast cancer (**Must report stage and size**)
- ❑ Ductal carcinoma in situ
- ❑ Lobular carcinoma in situ
- ❑ Reoccurrence of prior breast cancer

20. Tumor stage:

AJCC/TNM	Summary Stage
❑ Stage I	❑ Local
❑ Stage II	❑ Regional
❑ Stage III	❑ Distant
❑ Stage IV	❑ Unknown

21. Tumor size: _____cm

TREATMENT STATUS

22. What is the status of breast cancer treatment?
- ❑ Treatment started
- ❑ Client lost to follow-up (**Complete Refused/LTFU Form**)
- ❑ Treatment refused (**Complete Refused/LTFU Form)**
- ❑ Treatment not recommended

23. Date of treatment status: / / (mm/dd/yyyy)

24. Type of treatment recommended: *(***Check all that apply***)*
- ❑ Mastectomy
- ❑ Lumpectomy
- ❑ Re-excision of biopsy site
- ❑ Wedge resection
- ❑ Quadrantectomy
- ❑ Chemotherapy
- ❑ Radiation therapy
- ❑ Hormonal therapy
- ❑ Bone marrow transplant
- ❑ Other:

25. Was the client enrolled in Medicaid for treatment?
❑ Yes ❑ No
If no, why not? _____

Form Completed by:

Cervical Screening and Diagnostic Form
Pap Test and Pelvic Exam

Pelvic Exam and Pap Test Date

Provide the dates when the pelvic exam and the pap test were done.

Pap Test Results

The Pap test results must be coded according to the new 2001 Bethesda System for reporting cervical cytologic diagnoses refer to http://www.bethesda2001.cancer.gov

These are the categories used for the collection of the Pap results:

- ❑ Negative (for intraepithelial lesion or malignancy)
- ❑ ASC-US
- ❑ LGSIL
- ❑ ASC-H
- ❑ HGSIL
- ❑ Squamous cell carcinoma
- ❑ Abnormal Glandular Cells (AGC)
- ❑ Other results:_____
- ❑ Not needed or done previously elsewhere with non EWL funds
- ❑ Needed but not performed (includes refused)
- ❑ Result unknown, presumed abnormal, from non-program funded source

- **Not needed or done previously elsewhere with non EWL funds**: There is no indication that a Pap test is needed because: (1) the client recently—within the last 12 months—received a Pap test from a non-EWL provider; (2) the client recently had a Pap test by the program and is returning for a short-term follow-up not related to cervical (e.g., repeat mammogram); (3) the client had a hysterectomy and does not require cervical cancer screening.

- **Needed but not performed (includes refused):** A Pap test is recommended for this cycle, but was not performed due to the following reasons: (1) the patient refused to have one; (2) the patient is lost-to-follow-up; (3) the patient was unable to obtain a Pap test due to scheduling; (4) the client had another procedure (e.g., colposcopy) done in lieu of a Pap test. With the latter, indicate that the recommendation was for planned workup.

- **Result unknown, presumed abnormal, from other funded source**: The client is being referred to the EWL for cervical diagnostic workup on the basis of an abnormal Pap test that was performed by a non-EWL provider. The finding is presumed abnormal, and therefore work-up is recommended. If the actual result from the outside Pap test is known, it should be fully reported in

the Cervical Screening section (complete the entire section); indicate "No" about the funding source. This result category should be reserved for screening test results that cannot be obtained.

Cervix Present

This indicates if the specimen was taken from the cervix or from the vaginal area. For women who have an intact cervix, the specimen will generally come from the cervix. The EWL does not reimburse Pap tests for women who had a hysterectomy not due to cervical cancer or dysplasia.

Specimen Type

Specimen Type indicates if the Pap test collection used a conventional, liquid-based technology (e.g., ThinPrep), or other method to collect the specimen.

Specimen Adequacy

Specimen Adequacy is either "satisfactory" or "unsatisfactory" according to the 2001 Bethesda System.

Pap Funding Source

If the Pap test was fully or partially paid by EWL, indicate 'Yes'.

HPV Test Result and Date

If an HPV test was done, indicate the result and date of the test.

Pap Test Provider

Indicate the location where the Pap test was performed and the specimen collected—that is, the clinic, Medical office or gynecological facility where the client had her Pap test performed—and not where the specimen was analyzed. Refrain from using initials or abbreviations.

Workup Recommendation

Specify if the clinician recommended workup based on the Pap test finding. The clinician should be following the guidelines for recommended work-up for abnormal Pap test, as provided by the EWL. If the recommendation is for short-term follow-up—i.e., to repeat the Pap test in six months or less—indicate "no" on the Workup Plan question.

Cervical Diagnostic Procedures

This section is for documenting diagnostic workup, the final diagnosis (if one is reached), and treatment information, if diagnosed with cervical cancer or dysplasis. You must complete this Form if you have an abnormal Pap test finding, or cervical diagnostic workup is recommended. *It is not necessary to submit blank Diagnostic Encounter Forms if no work-up is planned.*

Diagnostic work-up for abnormal cervical findings include the following major diagnostic procedures:

- colposcopy
- colposcopy-directed biopsy

Indicate which diagnostic test was performed, the procedure date, the procedure site, result, and funding source for the test. Additional procedures may be performed. If there is a procedure not in the list, write in under "Other" and provide the CPT code. If a test was cancelled or not performed because the patient refused or did not show for her appointment, indicate the test as "refused". If the patient refused a diagnostic test, complete the Refused/Lost to Follow up form.

NOTE: A verifying Pap test is not considered a diagnostic test and should not be documented on the Diagnostic Encounter Form.

NOTE: Procedures like loop electrode excision procedure (LEEP) and conization (cone biopsy) can be considered either treatment or a diagnostic test. If it is done for the purpose of diagnosing the cervical dysplasia, report it as a diagnostic test. If it is done to remove the area of abnormal cells, report it as treatment under the Cervical Cancer Treatment Status section.

Work-Up Status

Once work-up is completed, indicate the status of workup. Question 15 allows for you to report clients that refuse workup or are lost to follow-up. If the patient refused a diagnostic test, complete the Refused/Lost to Follow up form. In **all** cases of recommended work-up, you should complete Question 15, whether or not you have a final diagnosis.

Final Diagnosis Date

The Date of Final Diagnosis refers to the date of service of the procedure that results in the final diagnosis of cancer (or not cancer). If more than one diagnostic procedure was performed, the date of final diagnosis should be reported as the date of the procedure that provided the definitive diagnosis.

Diagnosis

The diagnosis categories vary from normal or benign to invasive cervical cancer. In some cases, you may have only a diagnosis of LGSIL or HGSIL based on a test other than a biopsy. Refer to the Diagnostic Encounter Form. If you have an alternative diagnosis (e.g., adenocarcinoma), please indicate under "Other" on Question 7.

Staging and Tumor Size

For cases of invasive cancer, report the tumor stage. It is not necessary to report the stage for in situ cancer (stage 0). The stage information can be obtained from your tumor registry or directly from the treating oncologist or surgeon.

For all cases of in situ or invasive cancer, you should complete the Cervical Cancer Treatment Status (see below).

Cervical Cancer Treatment Status

Treatment Status

For all cases of cancer diagnosed, you should at a minimum complete Question 19 on the status of treatment.

Report the date when treatment was started. **NOTE:** If a LEEP or conization was performed as both a diagnostic test and treatment to remove the abnormal cells, indicate the date of the procedure as the treatment start date.

For both Patient Lost to Follow-up and Treatment Refused, report a date when the determination was made—space is provided. If the patient refused treatment, complete the Refused/Lost to Follow up form.

Recommended Treatment

Check (✓) all treatments that are recommended. It is possible that the patient will not start or complete all recommended treatments—just indicate the treatments that are part of the clinician's plan.

Medicaid Enrollment

Indicate if the patient was enrolled in Medicaid under the provisions of the BCCPTA. Please send a copy of the BCCPTA Medicaid Application Form to VDH (and keep a copy for your own records). We will enter the date of enrollment in the state database.

Form Completed by

The Case Manager, or designee, who completed the form must sign and date the Diagnostic Encounter Form. If there are any questions regarding information on the form, the Nurse Consultant will contact that person.

Tips for Completing the Cervical Screening and Diagnostic Form

1. If more than one screening result was obtained, record the worse of the two results.
2. If the Pap test is unsatisfactory, submit the Cervical Screening and Diagnostic Form with the unsatisfactory finding. The Pap test should be repeated and the information submitted on a new form. This will help in tracking the number of unsatisfactory results.
3. If the client is being seen for a repeat mammogram or repeat CBE only, indicate that the Pap test was "not needed…". Do not leave the entire Cervical Screening section blank.
4. If the client is being referred to the EWL for diagnostic evaluation for a cervical problem on the basis of an abnormal Pap test by an outside provider, obtain and record the results of the Pap test and indicate that the Pap test was not paid by EWL.
5. A short-term follow-up, or repeat, Pap test is not a diagnostic test and should not be documented. Instead, indicate "No workup planned" and report the repeat Pap test on a new Cervical Screening and Diagnostic Form as part of a new screening cycle.
6. Endometrial biopsy may be reported under Other Diagnostic Procedure. Endometrial biopsy will typically be performed to evaluate atypical glandular cells (e.g., AGUS) for possible adenocarcinoma or endometrial cancer. Although the EWL does not reimburse for endometrial biopsies, the program still requires that abnormal glandular cells on the Pap test be evaluated.
7. If more than one result or final diagnosis is reported—for example, different findings on the colposcopy or biopsy—report the worse of the two findings.
8. If the result of the final, definitive diagnostic test (e.g., colposcopy-directed biopsy) is "indeterminate" and you indicate a final diagnosis of either cancer or no cancer, document an explanation for how you reached this diagnosis.
9. **Remember**: if the client is diagnosed with invasive cancer, you must report the tumor stage using the TNM staging system. Do not submit the pathology report, unless requested, as a substitute for reporting this information on the data form. You are responsible for choosing the correct category on the data form based on information that you obtain. If more than one tumor is found, choose the tumor stage that is worse. Consult with the treating physician, if possible, to obtain this information. In some cases, the Cancer Registry or your local hospital tumor registrar may be helpful

Cervical Screening and Diagnostic Form
Every Woman's Life - Virginia Department of Health

Last Name	**First Name**	**MI**	**Maiden Name**
Admin Site	❑ **New Patient** ❑ **Follow-up** ❑ **Rescreen**		**SSN (or alien ID)**

PAP TEST AND PELVIC EXAM

1. Pelvic exam date: _____ / _____ / _____ (mm/dd/yyyy)
2. Pap test date: _____ / _____ / _____ (mm/dd/yyyy)
3. What were the Pap test results?
   - ❑ Negative (for intraepithelial lesion or malignancy)
   - ❑ ASC-US
   - ❑ LGSIL
   - ❑ ASC-H
   - ❑ HGSIL
   - ❑ Squamous cell carcinoma
   - ❑ Abnormal Glandular Cells (AGC)
   - ❑ Other result: _____
   - ❑ Not needed or done previously elsewhere with non EWL funds
   - ❑ Needed but not performed (includes refused)
   - ❑ Result unknown, presumed abnormal, from non-program funded source
4. Cervix present? ❑ Yes (Cervical) ❑ No (Vaginal)
5. Specimen Type: ❑ Conventional ❑ Liquid-based ❑ Other
6. Specimen adequacy? ❑ Satisfactory ❑ Unsatisfactory - **Repeat Pap**
7. Was the Pap test paid by EWL? ❑Yes ❑ No
8. HPV Test Result? ❑ Positive ❑ Negative ❑ Not Done
   HPV test date: _____ / _____ / _____ (mm/dd/yyyy)
9. Where was the Pap test/Pelvic exam performed?
   Facility/Clinic: _____
10. Was the client referred for **immediate** cervical diagnostic workup? ❑Yes ❑ No

DIAGNOSTIC PROCEDURES

11. Colposcopy without Biopsy
❑ Yes ❑ No
Procedure Date :___ / ___ / ___
Procedure site:_____

Results:
- ❑ Negative (WNL)
- ❑ Clearly defined lesion of CIN
- ❑ Abnormal, suspicious for cancer
- ❑ Abnormal, but not suspicious for cancer
- ❑ Unsatisfactory
- ❑ Refused (**Complete Refused/LTFU Form**)

Funding Source: ❑ EWL ❑ Other

12. Colposcopy-directed Biopsy
❑ Yes ❑ No
Procedure Date: ___ / ___ / ___
Procedure site:_____

Results:
- ❑ Adenocarcinoma
- ❑ CIN I
- ❑ CIN II
- ❑ CIN III/CIS
- ❑ Invasive Carcinoma
- ❑ Negative (WNL)
- ❑ Other **Non-Cancerous** Abnormality
- ❑ Refused (**Complete Refused/LTFU Form**)

Funding Source: ❑ EWL ❑ Other

13. Other Procedure #1
❑ Yes ❑ No
Procedure Date: _____ / _____ / _____
- ❑ ECC
- ❑ LEEP
- ❑ Cone
- ❑ Other _____

Procedure site:_____

Results:
- ❑ Adenocarcinoma
- ❑ CIN I
- ❑ CIN II
- ❑ CIN III/CIS
- ❑ Invasive Carcinoma
- ❑ Negative (WNL)
- ❑ Other **Non-Cancerous** Abnormality
- ❑ Refused (**Complete Refused/LTFU Form**)

Funding Source: ❑ EWL ❑ Other

14. Other Procedure #2
❑ Yes ❑ No
Procedure Date: _____ / _____ / _____
- ❑ ECC
- ❑ LEEP
- ❑ Cone
- ❑ Other _____

Procedure site:_____

Results:
- ❑ Adenocarcinoma
- ❑ CIN I
- ❑ CIN II
- ❑ CIN III/CIS
- ❑ Invasive Carcinoma
- ❑ Negative (WNL)
- ❑ Other **Non-Cancerous** Abnormality
- ❑ Refused (**Complete Refused/LTFU Form**)

Funding Source: ❑ EWL ❑ Other

WORK-UP STATUS

15. What is the status of the final diagnosis?
- ❑ Work-up complete
- ❑ Client lost to follow-up (**Complete Refused/LTFU Form**)
- ❑ Work-up refused (**Complete Refused/LTFU Form**)

16. Date of final diagnosis: ____ / _____ / _____(mm/dd/yyyy)

17. Final diagnosis:
- ❑ Normal/Benign Reaction/Inflammation
- ❑ HPV/Condylomata/Atypia
- ❑ CIN I/Mild Dysplasia (biopsy diagnosis)
- ❑ CIN II/Moderate Dysplasia (biopsy diagnosis)
- ❑ CIN III/Severe Dysplasia/Carcinoma in situ (Stage 0) (biopsy diagnosis)
- ❑ Invasive Cervical Carcinoma (biopsy diagnosis) ***(Indicate staging information below)***
- ❑ Other: _____
- ❑ Low grade SIL (biopsy diagnosis)
- ❑ High grade SIL (biopsy diagnosis)

18. Tumor Stage

TNM	Summary Stage
❑ Stage I	❑ Local
❑ Stage II	❑ Regional
❑ Stage III	❑ Distant
❑ Stage IV	❑ Unknown/Unstaged

TREATMENT STATUS

19. What is the status of cervical cancer treatment?
- ❑ Treatment started
- ❑ Client lost to follow-up (**Complete Refused/LTFU Form)**
- ❑ Treatment refused (**Complete Refused/LTFU Form**)
- ❑ Treatment not recommended

20. Date of treatment status: _____ / _____ / _____(mm/dd/yyyy)

21. Type of treatment recommended: (**Check all that apply**)
- ❑ ECC
- ❑ LEEP
- ❑ Cone
- ❑ Cryosurgery
- ❑ Radiation Therapy
- ❑ Chemotherapy
- ❑ Hysterectomy
- ❑ Hormonal Therapy
- ❑ Other _____

22. Was client enrolled in Medicaid for treatment? ❑ Yes ❑ No
If **no**, why not? _____

Form Completed by:

Version 7/06

Refused/ Lost to Follow up Form

There are several reasons for a patient not receiving screening, diagnostic or treatment services: (1) the service is not needed; (2) the patient becomes "lost to follow-up"; or (3) the patient refuses the service, the latter two which are defined below. The Refused/Lost to Follow Up form should be completed for these clients.

Refused

In the event that the client refuses screening, diagnostic tests or treatment services either formally, by declaring so, or informally, by not keeping an appointment or canceling a scheduled appointment, you should indicate that the service is "refused".

Refused Test/Treatment

Write in which test or treatment the patient refused.

Indicate Reason

Check (✓) the reason the patient refused the test or treatment. If the refusal was due to an "other" reason, check (✓) that box and then specify the "other" reason on the line provided.

Case Management Interventions

Specify any interventions used to contact the client. Several attempts should be made to contact a client to schedule follow-up diagnostic services and treatment. Three telephone attempts should be made on three different dates. If the case manager is still unable to locate the client, a certified letter should be sent, return receipt requested. If there is still no response from the client, the case manager has the option of discharging the patient from the program.

Client Response

Indicate the client's response to the case manager's interventions.

Lost to Follow-up

In the event that the case manager cannot successfully contact the client, including cases where the client died or moved without a forwarding address, the client is considered "lost to follow-up". In this section, check (✓) the box to indicate if the client was lost to follow up for screening tests, rescreening tests, diagnostic tests, or treatment.

Case Management Intervention

Indicate the number of phone calls or number of certified letters sent by the case manager to the client.

Client Response

Indicate the client's response to the case manager's interventions.

Waiver Statement

For purposes of minimizing legal liability, attempts should be made to have the client sign the Waiver Statement on the bottom of the *Refused/Lost to Follow Up Form* or other substitute form that your facility has, if at all possible. *It is strongly suggested that you gather and document details behind the client's refusal.* Such comments will be added to the database and submitted to CDC upon request.

Refused/Lost to Follow up Form
Every Woman's Life - Virginia Department of Health

Last Name	First Name	MI	SSN (or Alien ID)

REFUSED

Refused which test/treatment:_____

Indicate Reason:
☐ Fear of Procedure ☐ Illness, Injury or Hospitalization ☐ Too Busy/Time Conflicts ☐ Transportation Problems
☐ Financial Problems ☐ Disagrees with Recommendations ☐ Moved ☐ Other _____

Case Management Interventions:_____

_____

Client Response:_____

_____

LOST TO FOLLOW UP

☐ Screening Tests ☐ Rescreening Tests ☐ Diagnostic Tests ☐ Treatment

Case Management Interventions:
# of Phone Calls:_____ # of Certified Letters:_____

_____

Client Response:_____

_____

Waiver Statement:

I certify that I have been advised as to the need for follow-up medical evaluation or treatment and the consequences of not getting this evaluation or treatment. I have decided to exercise my right to refuse any type of follow-up medical evaluation or treatment.

_____ _____/_____/_____
Signature *Date*

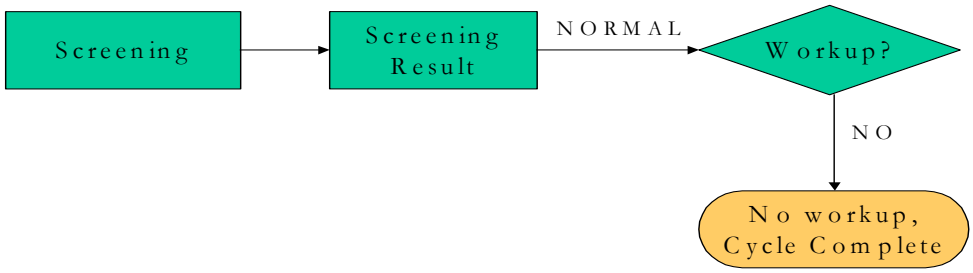
_____ _____/_____/_____
Witness Signature *Date*

Version 7/06

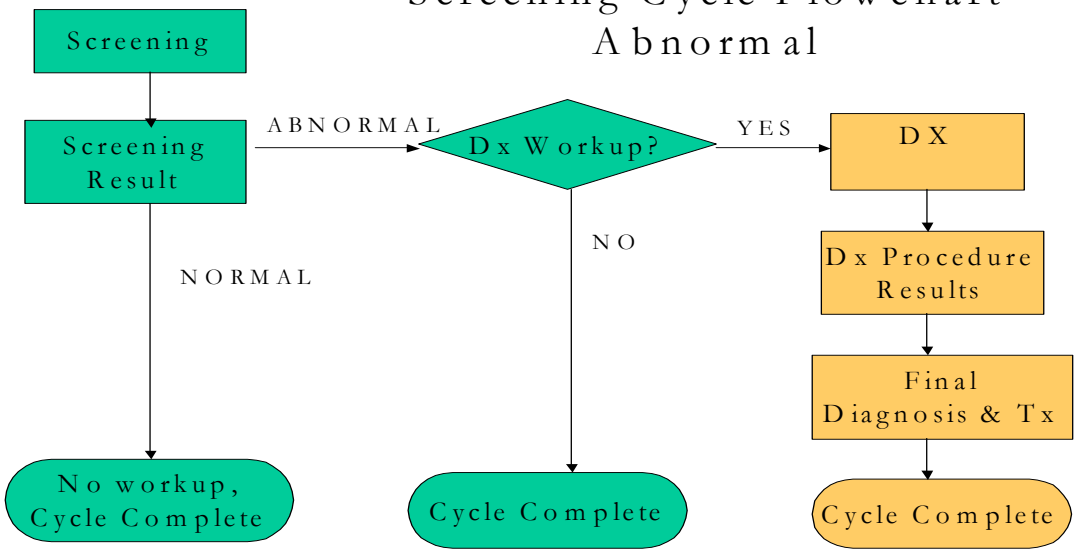
Screening Cycles

A screening cycle is comprised of the client's screening and any diagnostic work-up needed to further investigate an abnormal screening finding. To the EWL, a screening cycle usually begins with a Pap test, a clinical breast exam, and/or a screening Mammogram and ends, in most cases, with a normal screening result. For a woman with an abnormal screening result, the cycle is not complete until the diagnostic work-up, final diagnosis, and treatment information is completed.

Screening Cycle Flowchart Normal



Screening Cycle Flowchart Abnormal



RESCREENING

Re-Assessing Eligibility

Each year, the eligibility of the client must be reassessed. You should determine if the following information currently meets eligibility criteria:

- ☑ annual household income and household size (note that Federal Poverty Guidelines change annually)
- ☑ age
- ☑ residence
- ☑ insurance

You should also verify that address and telephone numbers are valid. Note any changes in name due to changes in marital status. You must complete a new Eligibility Form yearly when the client returns for rescreening. Date as the date when youre-interviewed the client. Ignore questions questions for new clients only.

Rescreening Cycle

An annual rescreen cycle is comprised of the same screening tests that were performed at a new screening cycle, that is, the CBE, Pap test, and mammogram. Document the screening information on the Screening and Diagnostic Forms, as you would if it were a new screen. Indicate “Rescreen” at the top of the Form.

Short Term Follow-up Cycles

This standardization of reporting a screening cycle does not always fit the realities of clinical practice. Often a clinician will recommend a repeat Pap test or mammogram in 3 months or 6 months based on a questionable result in the earlier screening. To the clinician, the repeat procedure is considered part of follow-up. For the purposes of reporting data to the CDC, the repeat Pap test or mammogram would begin a new screening cycle.

Short Term Follow-up/Planned Delay

Where there is a planned delay before doing a related test or procedure, the test begins a new screening cycle. The delay is planned **by the physician**. The following scenario helps illustrate this point.

Scenario One: Short Term Follow-up/Planned Delay
Carol had an initial screening mammogram in December with a result of Probably Benign (CBE was negative). The clinician told her to come back in March for a diagnostic mammogram on her left breast, which showed a negative result.

How to Report

- ☑ The initial mammogram in December should be recorded on the Breast Screening and Diagnostic Form. The result is Probably Benign.
- ☑ It should be noted that Diagnostic Work-Up is not Planned.
- ☑ The diagnostic mammogram in March of the following year should be recorded on a new Breast Screening and Diagnostic, with the Pap Test and CBE indicated as not performed. The type of mammogram performed is recorded as "Diagnostic".
- ☑ Once again, you should indicate that Diagnostic Work-up is not Planned as the last question on the Breast Screening and Diagnostic Form under the Mammogram section.

Explanation

For Carol, the results of the initial screening mammogram in December were Probably Benign. The clinician recommended instead Short Term Follow-Up, indicating a shortened screening cycle. This means that the doctor did not want any diagnostic tests done immediately, but wanted Carol to return at a later date for a another screening test. Whenever there is a planned delay before doing a test, the repeat test begins a new screening cycle, regardless of whether the cycle begins 3-, 6-, or 12-months from the date of the initial screening. Regardless of whether the repeat mammogram is called screening or diagnostic, if it is the first mammogram of a new screening cycle, it should be documented on the Screening Encounter Form.

Diagnostic Work-Up/Unplanned Delay

When the delay is unplanned or not recommended by the physician—that is, the client is the cause of the delay--the new test may remain as part of the same cycle as the initial screening and be considered diagnostic work-up. The following scenario illustrates this point.

Scenario Two: Diagnostic Work-up/Unplanned Delay
Jan has a screening mammogram in December. When the doctor read the film, she said that she wanted to do a diagnostic mammogram with additional views before deciding whether Jan needed further tests. Jan has left for Florida for the rest of the winter, so she had the diagnostic mammogram when she returned in March.

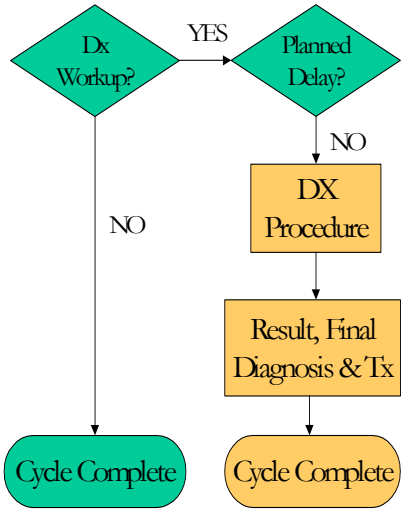
How to Report

- ☑ The initial mammogram in December should be recorded on the Breast Screening and Diagnostic Form. The result is Assessment Incomplete.
- ☑ Diagnostic Work-up Planned is noted (as 'Yes') on the Breast Screening and Diagnostic Form.
- ☑ The additional mammographic views/diagnostic mammogram in March is recorded on the Breast Screening and Diagnostic Form.
- ☑ If there is a need for further diagnostic workup, the cycle is not complete until all diagnostic tests are performed and recorded and a final diagnosis is determined.

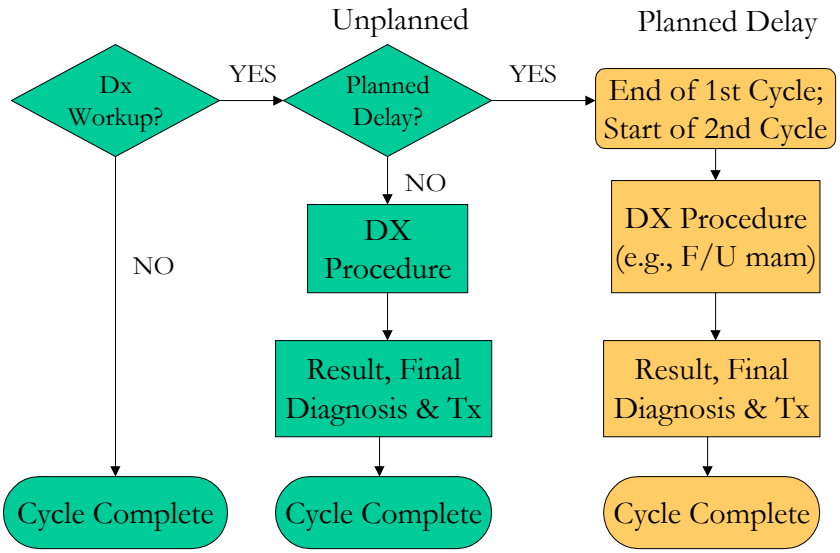
Explanation

On the surface, this looks like the previous scenario, but there are two important differences. The doctor in the first scenario wanted Carol to wait a few months before having the second mammogram. In this scenario, the doctor wants Jan to have the diagnostic mammogram right away, but Jan is out of town. The second difference is that in the first scenario, the initial screening mammogram result was Probably Benign. In this scenario, the result was Assessment Incomplete, which implies that the radiologist needed further imaging tests before making a conclusion about the screening mammogram. The screening cycle is still open until all diagnostic work-up is completed. It is not the amount of time that passes between the test that is relevant, but rather the initial screening finding and the reason for why the amount of time passed: was it on purpose or could it have been done sooner if possible?

Diagnostic Work-up/Unplanned Delay



SHORT-TERM FOLLOW-UP/PLANNED DELAY



Data Forms To Be Submitted

For a New Screen or Rescreen Cycle: You are required to send the following data forms—a "complete data packet"—per patient for a new patient cycle or rescreen patient cycle:

- ☑ Eligibility Form
- ☑ Breast and Cervical Screening and Diagnostic Forms

For a Short-Term Follow-Up Cycle: complete only the Breast and Cervical Screening and Diagnostic Forms. The Eligibility Form is valid for twelve months and does not need to be completed again before the next rescreening cycle

Appendix B

Breast Cancer – TNM Cancer Staging

STAGE 0	Ti.s.	NO	MO
STAGE I	T1	NO	MO
STAGE IIA	TO, T1	N1	MO
	T2	NO	MO
STAGE IIB	T2	N1	MO
	T3	NO	MO
STAGE IIIA	T0,T1,T2	N2	MO
	T3	N1,N2	M0
STAGE IIIB	Any T	N3	MO
	T4	Any N	MO
STAGE IV	Any T	Any N	M1

BREAST CANCER - PRIMARY TUMOR (T)

TX	Primary tumor cannot be assessed
TO	No evidence of primary tumor
Ti.s.	Carcinoma *in situ*: intraductal carcinoma, lobular carcinoma in situ, or Padget's disease with no tumor.
T1	Tumor 2 cm or less in greatest dimension
T1A	Tumor 0.5 cm or less in greatest dimension
T1B	Tumor more than 0.5 cm but not more than 1 cm in greatest dimension
T1C	Tumor more than 1 cm but not more than 2 cm in greatest dimension
T2	Tumor more than 2 cm but not more than 5 cm in greatest dimension
T3	Tumor more than 5cm in greatest dimension
T4	Tumor of an size with direct extension to chest wall or to skin
T4a	Extension to chest wall
T4b	Edema (including peau d'orange) or ulceration of the skin of the breast or satellite skin nodules confined to the same breast
T4c	Both T4a and T4b
T4d	Inflammatory carcinoma

BREAST CANCER - REGIONAL LYMPH NODES (N)

NX	Regional lymph nodes cannot be assessed (e.g., previously removed)
N0	No regional lymph node metastases
N1	Metastasis to movable ipsilateral axillary lymph node(s)
N2	Metastases to ipsilateral axillary nodes fixed to one another or to other structures
N3	Metastases to ipsilateral internal mammary lymph node(s)

BREAST CANCER - DISTANT METASTASIS (M)

MX	Presence of distant metastasis cannot be assessed
MO	No evidence of distant metastasis
M1	Distant metastases (including metastases to ipsilateral supraclavicular lymph nodes

Appendix C

STAGING OF CERVICAL CANCER

Stage 0 Carcinoma-in-situ

Stage I Tumor is confined to the cervix

- **IA** Microinvasive disease, with the lesion not grossly visible: no deeper than 5 mm and no wider than 7 mm
  - **IA1** Invasion <3 mm and no wider than 7 mm
  - **IA2** Invasion >3 mm but <5 mm and no wider than 7 mm
- **IB** Larger tumor than in IA or grossly visible, confined to cervix
  - **IB1** Clinical lesion no greater than 4 cm
  - **IB2** Clinical lesion greater than 4 cm

Stage II Extends beyond the cervix, but does not involve the pelvic side wall or lowest third of the vagina

- **IIA** Involvement of the upper 2/3 of vagina, without lateral extension into the parametrium
- **IIB** Lateral extension into parametrial tissue

Stage III Involves the lowest third of the vagina or pelvic side wall, or causes hydronephrosis

- **IIIA** Involvement of the lowest third of the vagina
- **IIIB** Involvement of pelvic side wall or hydronephrosis

Stage IV Extensive local infiltration or has spread to a distant site

- **IVA** Involvement of bladder or rectal mucosa
- **IVB** Distant metastases

Source: International Federation of Gynecology and Obstetrics (FIGO).

Appendix D

Provider Site:

(1) Fill in the number of federal and state screenings you were awarded for FY 2007-08 in the boxes to the right. **Federal** **State**
(2) Enter the number of new screens and re-screens each month for federal and state
(3) The Total, Cumulative Total, and Percent Screened will be **automatically** calculated for you.
(4) Enter the date you submit this screening log to VDH
(5) Submit the screening log by the 5th day of each month
(6) FAX your screening log to 804-864-7763; attention Beth Tanner

FEDERAL

	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	TOTAL
# New Screens													0
# Rescreens													0
Total (AUTO Calc)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0
Cumulative Total (AUTO Calc)	0	0	0	0	0	0	0	0	0	0	0	0	0
Percent Screened (AUTO Calc)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Date Submitted													

STATE

	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	TOTAL
# New Screens													0
# Rescreens													0
Total (AUTO Calc)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0
Cumulative Total (AUTO Calc)	0	0	0	0	0	0	0	0	0	0	0	0	0
Percent Screened (AUTO Calc)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Date Submitted													

Appendix E

Every Woman's Life
Community Health Worker Monthly Activity Summary Form

Name _____
Month _____**Year 200__**
****Please use two forms to report activity if you need more room**

Activity	Women Contacted	Comments (if applicable)
SAMPLE: *Made phone calls to women who missed appointments.*	15	*I was able to encourage one woman to come in to have follow-up testing done!*

Don't forget! CHW reports are due by the **5th day of each month**. If you do not have any activity for the month, please call or email to advise as such. Please fax your report to 804-864-7763 or email to Beth Tanner at beth.tanner@vdh.virginia.gov (phone 804-864-7759).

Appendix F

Every Woman's Life Program
Matching Funds Form
Fiscal Year 2007-08

Non-federal matching funds in the amount of $1 for every $3 of federal funds awarded is required. Please provide in the table below your **actual** matching funds for FY 2007-08 (June 30, 2007 – June 29, 2008) by **July 29, 2008.**

Non-Federal Cash Resources and Amounts:

Source	**Actual Amount By June 29, 2008**
• Cash donations	$
• Community fund-raising	$
• Other grants or awards *(e.g., Komen, Avon)*	$

Non-Federal Non-Cash Resources and Amounts:

Source	**Actual Amount By June 29, 2008**
• Donated vehicles and equipment *(e.g., vans for transportation, laboratory equipment, computers)*	$
• Donated clinical services *(e.g., professional salaries)*	$
• Donated non-clinical services *(e.g., clerical salaries)*	$
• Donated supplies *(e.g., educational materials, promotional materials)*	$
• Donated media time *(e.g., television, radio, print)*	$
• Donated professional time *(e.g., service on coalitions, advisory committees, advertising/marketing consultation)*	$

Appendix G

Every Woman's Life

CLIENT EDUCATION CHECKLIST

Client Name: _____

Enter the date and your initials in the appropriate box or write "NA", if not applicable.
Initial and sign at the bottom of the page with your credentials.

	Date Completed Initials	Date Completed Initials	Date Completed Initials	Date Completed Initials	Date Completed Initials
Basic anatomy & physiology					
Risk factors					
Current recommended guidelines					
Benefits of early detection					
BSE procedures					
Importance of monthly breast self-exam					
Clinical breast & pelvic exam procedures					
Mammography procedures					
Importance of regular breast and cervical cancer screening					
Exit education/instructions					
Other					
Other					

Initials	Signature & Credentials	Initials	Signature & Credentials

Appendix H

Every Woman's Life

CLIENT SERVICES FLOW SHEET

Client Name: _____

Enter the date and your initials in the appropriate box or write "NA", if not applicable. Initial and sign at the bottom of the page with your credentials.

	Date Completed/ Initials	Date Completed/ Initials	Date Completed/ Initials
Screening Appointment Scheduled			
Pre-Appointment Instructions			
Directions to Provider Site			
Transportation Assistance			
Clinical Breast Exam			
Pap Test DOS			
Pap Report Received			
Patient Notified of Pap Result			
Mammogram DOS			
Mammogram Report Received			
Patient Notified of Mammogram Results			
Other			
Other			
Breast F/U Due			
Breast F/U Appointment Date			
Cervical F/U Due			
Cervical F/U Appointment Date			
Annual Mammogram Due			
Annual Pap Due			
Rescreen: 1st Reminder Sent			
Rescreen: 2nd Reminder Sent			
Rescreen: 3rd Reminder (Phone)			
Other			
Other			
Other			

Initials	**Signature & Credentials**	**Initials**	**Signature & Credentials**

Appendix I

Insert Provider Letterhead

Invoice Date: _____ Federal Tax ID#_____
Invoice #_____ Contract #_____
Submitted by: _____
Provider Site Name

TO: Virginia Department of Health
Virginia Every Woman's Life (EWL) Program
109 Governor Street, 8th Floor, West
Richmond, Virginia 23219
Attention: Data Manager

Reimbursement is requested for expenses incurred for: **(complete for one type of expense only)**

Expense	**Description**	Amount Requested	**FOR STATE USE ONLY**	
			Amount Approved	**State Approval**
Client Screening	Screening, diagnostic and follow-up services (list clients and service dates on Client Screening List)	# Clients_____ $_____	# Clients_____ $_____	
CHW Support	Funds to support Community Health Worker[1]	$	$	
Colorectal Screening	Funds to support colorectal screening services[2]	# FIT_____ # Colon_____	FIT #_____ $_____ Colon #_____ $_____	
Other		$	$	

Send the approved amount to (*enter address in the space below*):

[1] Health Departments do not need to submit an invoice for CHW support.
[2] Request for colorectal screening services is limited to EWL pilot sites

Client Screening List – Federal

Invoice Date: ____________________ Invoice #____________________________

Screening data is submitted for payment on the following EWL clients (**list clients paid with <u>federal funds</u>**):

No.	**Client Name**	**Screening Date of Service**	FIT (Check if performed)	**Colonoscopy (Check if performed)**	STATE USE ONLY **<u>Approved</u>**

Client Screening List – State

Invoice Date: _____ Invoice #_____

Screening data is submitted for payment on the following EWL clients (**list clients paid with <u>state funds</u>**):

No.	Client Name	Screening Date of Service	STATE USE ONLY Approved

Client Screening List – Follow-Up

Updates/Short-term Follow-up Data (**not for payment**):

No.	Client Name	Screening Date of Service	STATE USE ONLY Approved

Appendix J

Management of Abnormal Breast Screening Results

#	CBE	Mammogram *	Diagnostic Procedures**
1	**Normal**	a) Negative b) Benign	No work-up required
2	**Normal**	a) Probably Benign	**No diagnostic work-up required, however, follow-up should include:** a) Six-month short-term follow-up exam with clinical breast exam and imaging b) Annual mammograms at one- and two-years should be diagnostic mammograms
3	Abnormal	**a) Negative** b) Benign c) Probably Benign d) Assessment Incomplete	One or more of the following procedures must be performed: a) Repeat breast exam by a surgeon. b) Ultrasound c) Biopsy/Lumpectomy with or without imaging d) Fine Needle/Cyst Aspiration
4	Abnormal	**a) Suspicious Abnormality** b) Highly Suggestive of Malignancy	One or more of the following procedures must be performed: a) Biopsy/lumpectomy b) Fine Needle/Cyst Aspiration
5	Normal	Suspicious Abnormality	**One or more of the following procedures must be performed**: a) Repeat breast exam by a surgeon with additional imaging as needed b) Biopsy/Lumpectomy with or without imaging c) Fine Needle/Cyst Aspiration
6	Normal or Abnormal	Highly Suggestive Of Malignancy	One or more of the following procedures must be performed: a) Biopsy/Lumpectomy with or without imaging b) Fine Needle/Cyst Aspiration
7	Normal	Assessment Incomplete	**One or more of the following procedures must be performed**: a) Additional mammographic views b) Ultrasound

*Perform a screening mammogram if preceded by normal CBE. Perform a diagnostic mammogram if preceded by abnormal CBE or in the presence of suspicious symptoms.

**** WHENEVER A DIAGNOSTIC WORK-UP IS PLANNED, AT LEAST ONE DIAGNOSTIC PROCEDURE MUST BE PERFORMED, THE FINAL DIAGNOSIS MUST BE RECORDED AND THE TIME FROM INITIAL SCREENING TO FINAL DIAGNOSIS MUST BE NO MORE THAN 60 DAYS.**

These guidelines are intended to provide guidance to clinicians caring for women with breast cancer screening abnormalities. It is intended that approaches will be individualized in order to take into account each patient's history, clinical findings and preferences; the algorithms are not considered a substitute for clinical judgment.

Adapted from the National Breast and Cervical Cancer Early Detection Program Policy and Procedures Manual, Centers for Disease Control and Prevention, October 2000

Revised and Approved by EWL MAC: 2/25/04, 3/30/05, 03/29/06

Appendix K

BETHESDA SYSTEM 2001

SPECIMEN TYPE: *Indicate conventional smear (Pap smear) vs. liquid-based vs. other*

SPECIMEN ADEQUACY

- ☐ Satisfactory for evaluation *(describe presence or absence of endocervical/transformation zone component and any other quality indicators, e.g., partially obscuring blood, inflammation, etc)*
- ☐ Unsatisfactory for evaluation ... *(specify reason)*
  - Specimen rejected/not processed *(specify reason)*
  - Specimen processed and examined, but unsatisfactory for evaluation of epithelial abnormality because of *(specify reason)*

GENERAL CATEGORIZATION *(optional)*

- ☐ Negative for Intraepithelial Lesion or Malignancy
- ☐ Epithelial Cell Abnormality: See Interpretation/Result *(specify 'squamous' or 'glandular' as appropriate)*
- ☐ Other: See Interpretation/Result *(e.g. endometrial cells in a woman > 40 years of age)*

AUTOMATED REVIEW
If case examined by automated device, specify device and result.

ANCILLARY TESTING
Provide a brief description of the test methods and report the result so that it is easily understood by the clinician.

INTERPRETATION/RESULT

NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY *(when there is no cellular evidence of neoplasia, state this in the General Categorization above and/or in the Interpretation/Result section of the report, whether or not there are organisms or other non-neoplastic findings)*

ORGANISMS:

- *Trichomonas vaginalis*
- Fungal organisms morphologically consistent with *Candida* spp
- Shift in flora suggestive of bacterial vaginosis
- Bacteria morphologically consistent with *Actinomyces* spp.
- Cellular changes consistent with Herpes simplex virus

OTHER NON-NEOPLASTIC FINDINGS *(Optional to report; list not inclusive):*

- Reactive cellular changes associated with
  --inflammation (includes typical repair)
  --radiation
  --intrauterine contraceptive device (IUD)
- Glandular cells status post hysterectomy
- Atrophy

OTHER

- Endometrial cells *(in a woman > 40 years of age)*
  (Specify if 'negative for squamous intraepithelial lesion')

EPITHELIAL CELL ABNORMALITIES

SQUAMOUS CELL

- Atypical squamous cells of undetermined significance (ASC-US)
  cannot exclude HSIL (ASC-H)
- Low grade squamous intraepithelial lesion (LSIL) encompassing: HPV/mild dysplasia/CIN 1

- High grade squamous intraepithelial lesion (HSIL) encompassing: moderate and severe dysplasia, CIS/CIN 2 and CIN 3 with features suspicious for invasion (if invasion is suspected)
- Squamous cell carcinoma

GLANDULAR CELL

- Atypical
  --endocervical cells (NOS *or specify in comments*)
  --endometrial cells (NOS *or specify in comments*)
  --glandular cells (NOS *or specify in comments*)
- Atypical
  --endocervical cells, favor neoplastic
  --glandular cells, favor neoplastic
- Endocervical adenocarcinoma *in situ*
- Adenocarcinoma
  --endocervical
  --endometrial
  --extrauterine
  --not otherwise specified (NOS)

OTHER MALIGNANT NEOPLASMS: *(specify)*

Appendix L

Clinical Categories for Clinical Breast Exam

1. Normal Exam
2. Benign Finding (such as fibrocystic changes, diffuse lumpiness or nodularity)
3. Discrete palpable mass (includes masses that may be cystic or solid)
4. Bloody or serous nipple discharge
5. Nipple or areola scaliness
6. Skin dimpling or retraction
7. Previous normal CBE in past 12 months-CBE not done today
8. CBE not done today-other or unknown reason
9. CBE refused

Clinical Categories	**MDE Categories**
1,2	1=normal/benign findings—schedule for a routine CBE in one year
3,4,5,6	2=abnormality suspicious for cancer—diagnostic evaluation needed
7	3=not needed
8,9	4=needed but not performed at this visit (includes refused)

Appendix M

ACR (BI-RADS) Reporting Categories
DEFINITIONS, AND MAMMOGRAPHY FOLLOW-UP

Recommended follow-up by the EWL Medical Advisory Committee is indicated in italics

BI-RADS Category	DESCRIPTION	DEFINITION/RECOMMEDED FOLLOW-UP
1	Negative	There is no reason for comment. The breasts are symmetrical and no masses, architectural disturbances or suspicious calcifications are present. *Recommend routine annual mammogram for women over 40*
2	Benign Finding-Negative	This is also a negative mammogram, but the interpreter may wish to describe a benign finding. Involuting calcified fibroadenomas, multiple secretory calcifications, fat containing lesions such as oil cysts, lipomas, galactoceles, and mixed density hamartomas all have characteristic appearances, and may be labeled with confidence. The interpreter might wish to describe intramammary lymph nodes, implants, etc. while still concluding that there is no mammographic evidence of malignancy. *Recommend routine annual mammogram for women over 40.*
3	Probably Benign	A finding placed in this category should have a very high probability of being benign. It is not expected to change over the follow-up interval, but the radiologist would prefer to establish its stability. *Short-term follow-up-repeat mammogram in three to six months and/or surgical evaluation if recommended by the physician.*
4	Suspicious Abnormality	These are lesions that do not have the characteristic morphologies of breast cancer but have a definite probability of being malignant. The radiologist has sufficient concern to urge a biopsy. If possible, the relevant probabilities should be cited so that the patient and her physician can make the decision on the ultimate course of action. *Diagnostic mammogram and/or additional work-up within one month*
5	Highly Suggestive of Malignancy	These lesions have a high probability of being cancer. Appropriate action should be taken. *Diagnostic mammogram and/or additional work-up within one month.*
0	Assessment Incomplete	This almost always used in a screening situation and should rarely be used after a full imaging work-up. A recommendation for additional evaluation should be made including the use of spot compression, magnification, special mammographic views, ultrasound, aspiration, etc. *Diagnostic mammogram and/or additional work-up within one month.*
	Unsatisfactory	*Repeat screening mammogram immediately.*
	Not Indicated	*Screening mammogram within one to two years of last screening based on ACS guidelines.*
	Indicated, Not Performed	*Patient refused or failed to keep appointment-try to reschedule as soon as possible*.

Categories, descriptions and definitions from BI-RADS, Second Edition, September 1995

AN OVERALL (SUMMARY) IMPRESSION:
All final impressions should be complete with each lesion fully categorized and qualified. An indeterminate reading should only be given in the mammography screening setting where additional evaluation is recommended before a final opinion can be rendered. In the screening situation a suggestion for the next course of action should be given if the study is not conclusive (magnification, ultrasound, etc.)

Interpretation is facilitated by recognizing that most mammograms can be categorized under few headings. If a suspicious abnormality is detected, the report should indicate that biopsy should be considered. This is an assessment where the radiologist has sufficient concern that a biopsy is warranted unless there are other reasons why the patient and her physician might wish to defer the biopsy. Whenever possible, the present mammogram should be compared to previous studies. The radiologist should use judgment in how vigorously to pursue previous studies.

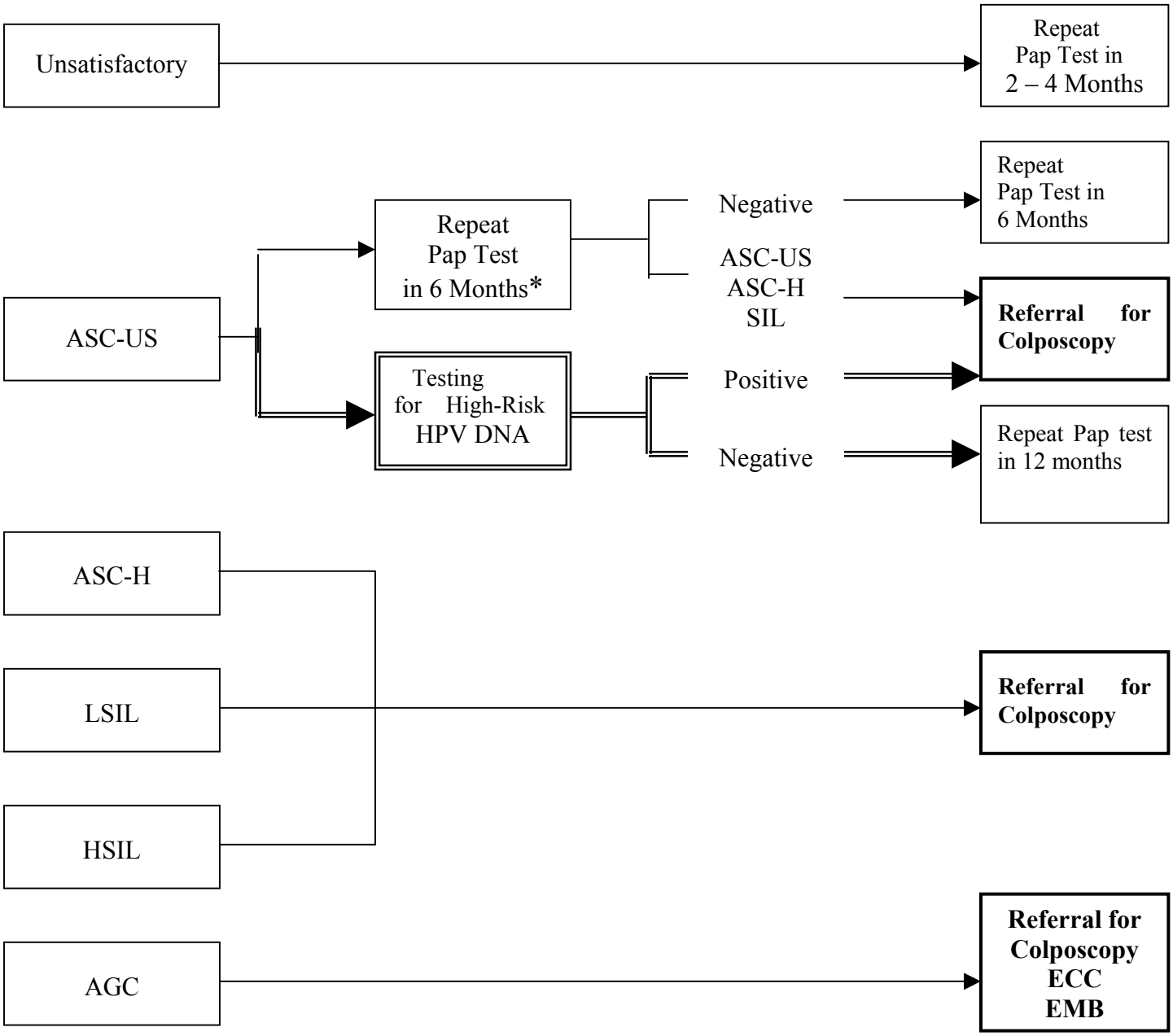
Appendix N

ALGORITHMS FOR THE MANAGEMENT OF ABNORMAL CERVICAL SCREENING RESULTS

Pap tests are intended as a screening tool in asymptomatic women and in the absence of visible lesions. In the presence of symptoms or visible lesions, the client should be referred for work-up.

These algorithms are provided as a supplement to the 2001 Consensus Guidelines for the Management of Women with Cervical Cytological Abnormalities as published by the ASCCP.

Please refer to the complete guidelines at http://www.asccp.org, if you have questions or require additional information.



*When a conventional dry-mount Pap test is performed, follow-up of a result of ASC-US includes repeat Paps at 6 and 12 months. If abnormal (anything other than negative), refer for colposcopy.

Approved by the EWL MAC: 3/30/05, 3/29/06

Appendix O

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application

AGENCY USE ONLY

DATE RECEIVED:

CASE NAME/NUMBER:

LOCALITY: | WORKER

Please complete all sections. If you need assistance, please contact an eligibility worker at your local Department of Social Services.

1. IDENTIFYING INFORMATION

LAST NAME: FIRST NAME: MI:

SOCIAL SECURITY NUMBER:

ADDRESS: CITY: STATE: ZIP:

STATE OF RESIDENCE:

MAILING ADDRESS (If different): CITY:

STATE: ZIP:

HOME PHONE #: DAYTIME PHONE #:

2. ADDITIONAL INFORMATION

RACE: ☐ WHITE ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ BLACK ☐ ASIAN/PACIFIC ISLANDER ☐ HISPANIC ☐ OTHER

MARITAL STATUS: ☐ NEVER MARRIED ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

U. S. CITIZEN? YES ☐ NO ☐ IF NO, ALIEN NUMBER: _____

DO YOU RECEIVE SSI? YES ☐ NO ☐ ARE YOU PREGNANT? YES ☐ NO ☐ DO YOU HAVE A CHILD(REN) UNDER AGE 19 LIVING WITH YOU? YES ☐ NO ☐

DO YOU HAVE HEALTH INSURANCE? YES ☐ NO ☐ IF YES, COMPANY NAME: _____

POLICY #: _____ EFFECTIVE DATE: _____ TYPE OF COVERAGE: _____

DID YOU RECEIVE MEDICAL CARE IN ANY OF THE THREE MONTHS BEFORE THIS APPLICATION? YES ☐ NO ☐ IF YES, LIST MONTHS: _____

3. BCCPTA CERTIFICATION

I CERTIFY THAT THE ABOVE NAMED INDIVIDUAL IS A VIRGINIA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (BCCEDP) PARTICIPANT (TITLE XV) AND IS ELIGIBLE FOR MEDICAID UNDER THE BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000.

SCREENING DATE: _____ DIAGNOSIS DATE: _____ FACILITY/SERVICE SITE: _____ PHONE #: _____

SIGNATURE OF BCCEDP CASE MANAGER: _____ DATE: _____

YOUR RIGHTS AND RESPONSIBILITIES

By signing below, I agree to the following:
I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs or disability consistent with state and federal law and to file a complaint if I feel I have been discriminated against.
- Have my eligibility for Medicaid benefits determined within 10 working days of receipt of my application at my local department of social services *or be notified of the reason for any delay*.
- Appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application; (2) denied benefits from the Medicaid program; or (3) dissatisfied with any other decision that affects my receipt of Medicaid benefits.

I have the responsibility to:

- Not purposely withhold information, or give false information and understand if I do so my Medicaid coverage may be denied or ended.
- Report any changes in information provided on this form within 10 days to my local department of social services.
- Cooperate with a review of my Medicaid eligibility by Quality Control and understand that refusing to cooperate will make me ineligible for Medicaid until I cooperate with a review.

I further understand and agree that:

- This application is used only to apply for Medicaid under the Breast and Cervical Cancer Prevention and Treatment Act coverage group and that in order to apply under other coverage groups I must complete another application.
- The Department of Medical Assistance Services and the Department of Social Services are authorized to obtain any verification necessary to establish my eligibility for Medicaid.
- The Department of Medical Assistance Services has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by me.
- Each provider of medical services may release any medical records pertaining to any services received by me.
- I am assigning my rights to medical support and other third party payments to the Department of Medical Assistance Services in order to receive benefits from the Medicaid program.

I declare that all information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information or fail to report a change promptly or on purpose I may be breaking the law and could be prosecuted for perjury, larceny and/or fraud. I understand that my signature on this application signifies, under penalty of perjury, that I am a U.S. citizen or alien in lawful immigration status.

_____ _____

Signature or Mark **Date**

_____ _____

Witness/Authorized Representative **Date**

VOTER REGISTRATION

Check one of the following:

( ) I am not registered to vote where I currently live now, and I would like to register to vote here today. I certify that a voter registration form was given to me to complete. (If you would like help in filling out the voter registration, we will help you. The decision to have us help you is yours. You also have the right to complete your form in private.)
( ) I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)
( ) I do not want to apply to register to vote.
( ) I do want to apply to register to vote, please send me a voter registration form.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497. The phone number is (804) 786-6551.

Appendix P

M0320.312 - BREAST AND CERVICAL CANCER PREVENTION AND TREATMENTACT (BCCPTA)

A. Policy

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 (P.L. 106-354) provides for payment of medical services for certain women with breast and cervical cancer. Virginia has chosen to cover this group beginning July 1, 2001.

Women eligible in this group have been screened by a medical provider operating under the Center for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program and have been certified as needing treatment for breast or cervical cancer, including pre-cancerous conditions. These women must be under age 65 and must not have creditable health insurance coverage for treatment of breast or cervical cancer.

B. Nonfinancial Eligibility

1. Required Nonfinancial Requirements

BCCPTA women must meet the following Medicaid nonfinancial requirements in chapte M02:

- *citizenship/alien status;*
- *Virginia residency;*
- *social security number provision/application requirements;*
- *assignment of rights to medical benefits requirements;*
- *application for other benefits; and*
- *institutional status.*

In addition, BCCPTA women must not be eligible for Medicaid under the following mandatory categorically needy covered groups:

- *LIFC;*
- *MI Pregnant Women;*
- *SSI recipients.*

2. Creditable Health Insurance Coverage

BCCPTA women must not have creditable health insurance coverage for the treatment of breast or cervical cancer. Creditable health insurance coverage includes:

- *a group health plan;*
- *health insurance coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;*
- *Medicare;*
- *Medicaid;*
- *armed forces insurance;*
- *a medical care program of the Indian Health Service (IHS) or of a tribal organization;*
- *a state health risk pool.*

There may be situations where a woman has creditable health insurance coverage as defined above, but the coverage does not include treatment of breast or cervical cancer due to a period of exclusion or exhaustion of lifetime benefits.

C. Financial Eligibility

There are no Medicaid financial requirements for the BCCPTA covered group. The CD Breast and Cervical Cancer Early Detection Program has income and resource requirements that are used to screen women for this program.

D. Application Procedures

The application procedures for women who meet the BCCPTA non-financial requirements have been streamlined to facilitate the prompt enrollment and immediate access to services for women who are in need of treatment for breast or cervical cancer. In addition to the nonfinancial information required to evaluate eligibility in the BCCPTA covered group, the following information is needed for enrollment in Medicaid:

- name,
- address,
- sex and race,
- date of birth,
- country of origin and entry date, if an alien.

Women who meet the description of individuals in the LIFC, MI pregnant women or SS recipients covered groups must complete the appropriate Medicaid application for the covered group and must have a Medicaid eligibility determination completed prior to determining their eligibility in the BCCPTA covered group. If not eligible in the LIFC, MI pregnant women or SSI recipients covered groups, then determine their eligibility in the BCCPTA covered group.

1. Application Form

The BCCPTA Medicaid Application/*Redetermination*, form #032-03-384, was developed for this covered group only. The application includes the *Breast and Cervical Cancer Early Detection Program* certification of the woman's need for treatment and the information needed to determine the nonfinancial eligibility in the BCCPTA covered group. Appendix 1 to this subchapter contains a copy of the BCCPTA Medicaid Application/ *Redetermination*.

If eligibility in another Medicaid covered group must first be determined, the applicant must be given the appropriate Medicaid application.

2. Application Processing Time Frames

BCCPTA Medicaid applications filed by women who do not meet the description of an individual in the LIFC, MI pregnant women or the SSI recipients covered groups must be processed within 10 working days of the agency's receipt of the signed application.

BCCPTA Medicaid applications filed by women who meet the description of an individual in the LIFC, MI pregnant women or the SSI recipients covered groups must be processed as soon as possible, but no later than 45 days of the agency's receipt of the signed application.

3. Notices

If the BCCPTA Medicaid application is the only application required and no additional information is required, the eligibility decision must be made immediately and applicant must be notified of the decision within 10 working days of the agency's receipt of the application.

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a "Notice of Action on Medicaid", form #032-03-008, on the 10th day stating why action has not been taken, specifying what information is needed and a deadline for submitting the information.

***E.* Entitlement**

1. Entitlement Begin Date

Medicaid eligibility in the BCCPTA covered group can begin no earlier than July 1, 2001. *Eligibility under this covered group is met the beginning of the month the screening is completed if the woman later has a positive diagnosis as a result of the screening and is determined to be in need of treatment for her breast and/or cervical cancer.*

Eligible BCCPTA women are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month, but no earlier than July 1, 2001.

2. Retroactive Entitlement

Retroactive coverage is applicable to this covered group if the individual was screened by a medical provider operating under the CDC *Breast and Cervical Cancer Early Detection Program* and diagnosed as needing treatment for breast or cervical cancer in the retroactive month(s*)*. However, coverage can begin no earlier than July 1, 2001.

F. Enrollment

The PD for BCCPTA women is "66".

G. Redetermination

Annual redetermination requirements are applicable to the BCCPTA covered group. Section 3 on the BCCPTA Application/Redetermination, form is not applicable at redetermination. At the time of the annual redetermination, the recipient must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer.

Appendix Q

Medicaid Treatment Act
FAQ Sheet

1. **If a woman has private health insurance would she be eligible for the Medicaid Treatment Act?**

Answer: The guidance from CMS says that the woman must not otherwise have creditable coverage (including current enrollment in Medicaid), as the term is used under HIPAA. Our policy at M0320.312 states that the woman must not have creditable health insurance coverage for the treatment of breast or cervical cancer. Creditable health insurance coverage includes:

- a group health plan;
- health insurance coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;
- Medicare;
- Medicaid;
- armed forces insurance;
- a medical care program of the Indian Health Service or of a tribal organization;
- a state health risk pool.

We go on to say that there may be situations where a woman has creditable health insurance as defined above, but the coverage does not include treatment of breast or cervical cancer due to a period of exclusion or exhaustion of lifetime benefits.....

Those women would not be eligible for coverage in the BCCPTA program because they have creditable coverage.

If a woman has a disease specific policy, such as a cancer policy, then that's not creditable health insurance and the woman could be eligible.

If a woman has a dental only policy or a vision only policy or a prescription drug policy, but no other coverage, then that's not creditable coverage and the woman could be eligible.

However, if the woman has creditable coverage, but a high deductible,
thne she is not eligible.

2. **Are women who move to VA and participated in the NBCCEDP program in another state eligible for the Medicaid Treatment Act?**

Answer: A woman enrolled and diagnosed with cancer under the NBCCEDP and is currently receiving treatment or in need of treatment is eligible for the Medicaid Treatment Act in VA.

Medicaid Treatment Act
FAQ Sheet

3. **Do we have presumptive eligibility in VA?**

Answer: Medicaid does not have presumptive eligibility in Virginia. Medicaid has streamlined the eligibility process for the BCCPTA but they do not approve and enroll anyone based on presumptive eligibility. Medicaid has an application and certification to determine if the individual meets the requirements of the BCCPTA covered group.

4. **Are women who received treatment for breast and/or cervical cancer through the BCCPTA eligible for re-entry into BCCPTA if complications arise from their previous treatment?**

Answer: If a woman is no longer under treatment and has been discharged from Medicaid, she is not eligible for re-entry into Medicaid for complications related to her treatment. She could apply for 'regular' Medicaid.

5. **Is reconstructive surgery covered under the BCCPTA?**

Answer: If a Medicaid provider obtains preauthorization for the surgery and determines it to be medically necessary it will be covered. To obtain preauthorization the Medicaid provider will need to submit the required paperwork.

6. **Is the cost of a wig allowable under the BCCPTA?**

No, the Medicaid Treatment Act does not cover the cost of a wig since it is considered a 'cosmetic' expense.

7. **Do BCCEDP women trying to enter Medicaid for treatment need to provide proof of citizenship and identify?**

Answer: Yes, this new rule applies to BCCPTA women. The Deficit Reduction Act of 2005, which was signed into law by President Bush on February 8, 2006, implements a new requirement for all applicants and recipients of Medicaid who claimed, at the time of application, to be US Citizens. This new provision requires individuals to provide documentation of citizenship and identity for all applicants who file an application for Medicaid on or after 7/1/06 and for all recipients of Medicaid at the time of their first redetermination of eligibility on or after 7/1/06. Provision of these documents is a one time activity....once provided, they will not be required again.

Citizenship can be documented in several ways.....but a birth certificate is probably the easiest. If the applicant does not have a birth certificate and needs assistance in obtaining one, the person can let the eligibility worker know and assistance can be provided.

Documentation of identity must also be provided. The easiest way to document identity is with a driver's license.

Of course, if we have a person with a passport or naturalization certificate, that would document both citizenship and identity.

Medicaid Treatment Act
FAQ Sheet

Original documents must be provided and the eligibility worker will make a copy for the case file.

Current recipients have been mailed a letter outlining the new requirements and have been provided with a list of acceptable verification.

This is a huge change for our applicants and recipients. Prior to July, all an individual had to do was declare US Citizenship and then sign the application under penalty of perjury that the information was true. This imposes a new requirement for provision of documents on the individual and sometimes those documents can be hard to obtain. Since this is a federal mandate, we have no discretion as to implementation.

8. **Can the EWL provider obtain proof of citizenship and identity and fax a copy of this information along with the Medicaid application to DSS?**

Answer: DMAS has agreed to the following for **health department providers only**:

If the EWL provider views the ORIGINAL documentation, copies it and annotates the copy(ies) with the words:

The original documentation was viewed by _____(name) an employee of _____(name of organization) on _____(date).

9. **Is there a co-pay for Medicaid services?**

Answer: Yes. Most Medicaid recipients other than pregnant women and children have co-pays for the Medicaid services they receive. Clients are responsible for the co-pay. Below is a list of co-pays for specific services:

Inpatient hospital $100 per admission
Outpatient hospital $ 3.00 per visit
Clinic visit $1.00 per visit
Physical office visit $1.00 per visit
Other physician visit $3.00 per visit
Eye Exam $1.00 per exam
Prescriptions $1.00 and $3.00
Home health visit $3.00 per visit
Rehabilitation service $3.00 per visit

Emergency Services are never subject to co-pays.

Medicaid Treatment Act
FAQ Sheet

10. **An EWL provider has asked if DSS can notify case managers when the final determination for Medicaid eligibility is made. DSS has stated this would not be a feasible practice for them but has provided some important resources that will assist you when a client fails to respond to your follow up calls for information.**

Answer: Please see the response from DSS below:

Medicaid policy requires notification to the applicant by local social service departments when enrollment is complete. Providers have access to a DMAS electronic system that allows them to see what benefits a Medicaid recipient who presents for services has as well as a toll-free provider hotline through DMAS when they have any questions about an individual's eligibility. With the number of providers, it is not feasible for DSS staff, whose primary responsibility is to address client needs, to notify providers when an individual qualifies for a service through Medicaid enrollment given the services already available to providers.

You may direct your providers to the DMAS website, www.dmas.virginia.gov since it has a great deal of information for providers. Additionally, there is a toll free number 800-884-9730 (Richmond area) or 800 552-8627 (outside Richmond area) to call for eligibility information.

11. **Does retroactive coverage under the BCCPTA only include the cost of diagnostics related to the breast and cervical cancer diagnosis or does it include all medical expenses (diabetes, heard disease, etc.) that are incurred by the woman?**

Answer: If the woman was eligible for the retro month, then Medicaid could be billed for all Medicaid covered services received during that month. Medicaid can be billed by the provider for services during that month. If the individual has already paid for the service, and it's something Medicaid would have covered, the provider may agree to bill Medicaid and then reimburse the individual. It is not mandatory that providers do that though and Medicaid does not reimburse recipients for services, only providers.

12. **Does a woman that receives the Family Planning Medicaid Waiver qualify for the Medicaid Treatment Act?**

Answer: Yes, Medicaid considers the Family Planning Medicaid Waiver as optional coverage. This waiver extends coverage to postpartum women up to 24 months after the baby is born and provides limited services, such as STD screens, yearly pap, and birth control bills. Medicaid eligibility for this coverage will be changing in 2007-2008 to include men and women under 133% FPL; it will no longer be directly tied to a pregnancy. Providers should notify their local DSS office if a woman is currently enrolled under the waiver program, since they will need to be un-enrolled before they can be enrolled into the BCCPTA.

Medicaid Treatment Act
FAQ Sheet

13. When completing Medicaid applications for clients enrolled with state funding, what date do we put for the screening date at the bottom of the application? Is it the date of the abnormal Pap test or the date of EWL enrollment?

Answer: It is the date of the Pap test.

14. Is the race and marital status field required fields on the Medicaid Application Form?

Answer: Yes, race and marital status information is collected and reported to CMS.

15. The recent Deficit Reduction Act (DRA) of 2005 requires all applicants and recipients of Medicaid to be US Citizens. Does this new law mean that aliens (not being able to provide proof of citizenship) are no longer eligible for the BCCPTA?

Answer: The DRA requires all applicants and recipients of Medicaid who claim to be U.S. citizens provide documentation of their citizenship and identity. Prior to July 1, 2006, applicants and recipients who declared they were U.S. citizens did not need to provide proof. Under this new Act, they must now provide documentation. There was NO change in eligibility requirements for non-citizens. If an alien is screened and diagnosed through the EWL program and needs Medicaid, as long as she is a qualified alien eligible for full Medicaid benefits, she will be eligible.

16. Can women enrolled under the NBCCEDP in other states transfer into the EWL program in Virginia and continue to receive Medicaid if they are currently undergoing treatment?

Answer: Yes. Since the EWL program is part of the national BCCEDP, women receiving Medicaid under the Medicaid Treatment Act in other states, territories, tribal organizations or the District of Columbia can continue to receive these benefits in Virginia. Even though other states, territories, tribal organizations and the District of Columbia may have different program eligibility criteria (e.g., income $\leq$ 250%), and follow different Medicaid eligibility criteria, women transferred into Virginia will continue to be eligible for treatment.

To initiate the transfer, EWL programs should verify, and if possible receive documentation, that the woman was enrolled in a NBBCEDP program and was receiving treatment under this state/program. Once this is verified, the EWL provider will need to complete a Medicaid application and forward it to their local DSS office. Once treatment ends, the woman, if eligible for the EWL program, may be re-screened through the program. Women that are not eligible for the EWL program should be referred to other community resources for their routine cancer screening.

Medicaid Treatment Act
FAQ Sheet

17. Is there an annual re-enrollment into BCCPTA?

Answer: Yes, clients enrolled under the BCCPTA must complete a re-determination form, which is available at their local DSS office. They can either have the treating physician complete the certification section of the form or have the physician verify in writing that they continue to receive treatment for breast and/or cervical cancer.

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